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THE CAUSES OF UNWANTED PREGNANCY:

A Psychological Study

from

A Feminist Perspective

A Dissertation Presented

by

Edith Sparago Irons

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 1977

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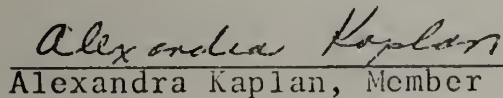
Edith Sparago Irons

Approved as to style and content by:

Alfred Alschuler, Chairperson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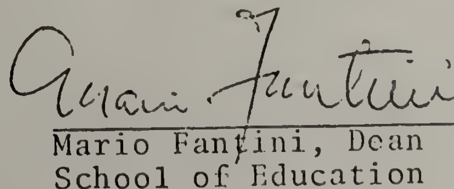
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School of Education

DEDICATION

To our much-wanted daughter, Elizabeth, who was with me throughout the writing of this dissertation, graciously waited to be born until the first draft of the last chapter was completed, slept peacefully between nursings so that I could make all the necessary revisions, and is a very great joy in my life.

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many, many thanks.

ABSTRACT

THE CAUSES OF UNWANTED PREGNANCY:
A Psychological Study
from
A Feminist Perspective

September 1977

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Unwanted pregnancies and births comprise a serious problem. The personal and social costs of unwanted pregnancies have been well documented, and it is generally conceded that more effective fertility management and family planning would serve both the individual and society. In spite of massive attempts to make contraceptive technology available to those who want to use it, a huge number of unwanted or problem pregnancies occur.

Research on the causes of unwanted pregnancy has alternatively focused on either the social context or individual psychological variables. Since it is impossible to separate the psychological and social variables related to fertility management behavior, this dissertation focuses on one important psycho-social explanation for unwanted pregnancies: the relationship between women's sex-role attitudes and their fertility management behavior. This study

revealed a significant, positive relationship between pro-feminist attitudes and success in managing fertility.

Chapter I includes critical review of the literature on the causes of unwanted pregnancy. Chapter III includes the results of a comparison of the attitudes towards female sex-role and perceptions of role appropriate behavior of four groups of women who, at the time of the study, differed in the way they were managing their fertility. Chapter IV interprets and summarizes the conclusions that may be drawn from the findings of this study, explores the implications of these findings for family planning researchers and practioners, and concludes with comments on the social and political ramifications of coercive and oppressive female sex-role definitions in relation to fertility management.

The literature reveals three general explanations for unwanted pregnancies: (1) contraceptive ignorance, (2) intrapsychic conflict, (3) social-sexual role internalization. Recent research has eliminated "contraceptive ignorance" as a <u>sufficient</u> explanation for unwanted pregnancy. The notion that intrapsychic conflict causes women to have unwanted pregnancies is based primarily on speculative, rather than empirical, studies. Both recent research and feminist politics point to the need for further empirical study of the proposition that internalization of an oppressive social-sexual role causes women to have

unwanted pregnancies. Such studies are more crucial, because presently, family planning agencies' prevention strategies rely on the two unsupported explanations for problem pregnancies.

In order to explore the relationship between women's sex-role attitudes and their fertility management behavior, this study compared the survey responses of women in four criterion groups: (1) effective contraceptors, (2) first abortion clients, (3) multiple abortion clients, and (4) problem pregnancy carriers. The thirty women in each group were compared on the seven survey outcome variables: (1) Spence's "Rights and Roles of Women in Society," (2) Ben's "Psychological Androgyny," (3) attitude toward abortion, (4) Miller's "Sexual Satisfaction," (5) Miller's "Sexual Regulation," (6) perceived work options, and (7) Miller's "Contraceptive Knowledge." The 120 subjects were randomly selected at three social agencies.

The differences among the groups were analyzed using multivariate analysis of variance to identify significant dimensions of difference among the groups. These differences were further analyzed to identify the specific variables accounting for differences between groups.

Although significant demographic differences occurred in the groups in spite of their random selection, a multivariate analysis of covariance revealed the principal

findings of this study were unaffected by these differences.

A significant, positive relationship was found between pro-feminist sex-role attitudes and more effective fertility management behavior. The four sex-role attitude measures accounted for the following percentages of variance between groups: attitudes toward women in society 28.5; psychological androgyny, 22.4; sexual regulation, 32.2; and sexual satisfaction, 18.9--all in the predicted direction. However, it appears that the effective contraception and abortion groups were more similar to each other than initially predicted, and all were more different from the problem pregnancy carriers' group than initially predicted.

This study confirmed that knowledge about contraception is not a critical determinant of effective fertility management behavior. A single significant difference was found between abortion and contraceptive clients: abortion clients were significantly more sexually regulated (less liberated). Women who avoided unwanted births--whether they used preconception or post-conception measures to do so--were significantly more pro-feminist than women who carried unwanted pregnancies to term.

PREFACE

My concern for the problem of unwanted pregnancy grew out of my experiences as Director of Counseling at Planned Parenthood of Greater Charlotte (PPGC) between May 1974 and May 1976. It was and is a concern shared with other staff members and, in particular, with the counseling staff. In fact, the major premise of this study--that there is a direct relationship between a woman's perception of female role and norms for role appropriate behavior and her success, or lack of success, in avoiding an unwanted pregnancy--really began to take shape in the weekly meetings we, the counseling staff, held to discuss our cases and review our work. It emerged slowly, over a two year period, and in collaboration with the other members of the counseling staff, as we struggled together to understand our experiences in counseling women, and/or couples, in the throes of an unwanted pregnancy.

When, in June 1974, PPGC expanded its services to include a counseling component, we were all new to family planning, per se. Our backgrounds were more in general counseling, social work, or public health. Not all of us were feminists. We shared different theoretical positions on how human beings develop, grow, and change, but we were all

committed to the notion that people can grow and change. Moreover, we shared the belief that individuals can be full participants in their own lives and live actively as opposed to passively. We were all intellectually committed to a woman's right to control her own body and reproductive life. As far as abortion was concerned, we were all pro-choice, believing that women are entitled to abortion on demand. At the same time, we all shared the belief that pre-conception methods of birth control (i.e., contraception) were a "better" choice than post-conception methods (i.e., abortion). We viewed abortion-on-demand as a viable backup for contraceptive failure. We believed then, as now, that the availability of safe, inexpensive, legal abortion was an absolute necessity.

Early on, I think we all shared the belief that the major part of our task was to provide information about contraception, and easy access to resources. We sincerely believed that if people knew about contraception, knew how to use it, and had ready access to it, they would choose to use it and thus avoid unwanted pregnancies. A great deal of our counseling time was spent in sharing information about methods of birth control. The first time we saw one of our contraception clients return to the agency with an unwanted pregnancy, we assumed it was an aberation. After several others, we questioned our own effectiveness. Were we

explaining contraceptive methods properly? We practiced our explanations, utilized more teaching aids, rewrote our pamphlets; the agency invested in audio-visual equipment. Eventually we began questioning our problem pregnancy and abortion clients to determine whether or not they knew anything about contraceptive methods and/or how to use them. They did.

At that point, as we saw more and more clients who knew about contraception <u>and</u> were pregnant with unwanted pregnancies, we seriously considered a notion of intra-psychic conflict. Were the women we were seeing deviant? But there were so many of them. Were they neurotic or pathological, self-punitive or self-destructive? A few exhibited varying symptoms of pathology; but the majority were quite obviously relatively healthy women, functioning beautifully in other areas of their lives. We were stumped. We were also quite frustrated.

It was only then that we really began to listen to our clients and to their own explanations for their unwanted pregnancies. Soon we realized that we were hearing the same recurring phrases, the same explanations over and over again. We began to tabulate responses, to put them in rough categories, such as "denial of sexuality," "testing fertility," "spouse or partner pressure," "no sense of choices." In our weekly meetings we began to talk less about the pathology

of individual clients and more about the social pressure on women to deny their sexuality and to become pregnant. As a group we felt that we were beginning to achieve some clarity about the causes of unwanted pregnancy and at the same time were aware that we had no hard evidence and no statistical support for our beliefs. Hence, this dissertation.

In all honesty this study would never have taken place without the collaborative effort of all those on the counseling staff. My thanks to each of them. To whatever extent this explanation of unwanted pregnancy is constructive and useful, credit for its development must be shared with them. Nor would this research have taken place without the support of the agency as a whole and the belief of Neil Leach, the Executive Director, and the Board of Directors in the importance of this study. Their provision of both moral and financial support made it possible for me to pursue this research. Again, many thanks. I sincerely hope my findings will be of use to them in their continuing efforts to provide family planning assistance to those who seek it.

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CHAPTER I

INTRODUCTION: THE PROBLEM OF UNWANTED PREGNANCY AND EXPLANATIONS OF THE PROBLEM

Major Premise of the Study

Is there a relationship between women's preceptions of female sex-role and their fertility management behavior? In other words, are there identifiable differences in attitudes towards the female sex-role of women who effectively use birth control, as compared with women who choose to abort unwanted pregnancies, and/or women who carry unwanted pregnancies to term? Is anyone of these groups of women any more or less stereotypically "feminine" than any other group? Do these groups of women differ significantly in terms of their attitudes towards the rights and roles of women? Do they differ in their attitudes towards female sexuality? Do they differ in their perceptions of the work options open to themselves as women?

The answers to these questions have important implications both for family planning practioners, who are attempting to assist people in managing their fertility, and for the social scientists who are attempting to understand the psychology of fertility management and birth

planning. The answers to these questions are of consequence, as well, to the social scientists who are attempting to understand the impact of sex role socialization on human behavior.

The major premise of this study is that there _is_ a relationship between women's perceptions of the female sex-role and norms for role appropriate behavior, and their fertility management behavior. More specifically, a direct relationship is predicted between the degree of profeminist views and the degree of success experienced in managing fertility, so as to avoid an unwanted pregnancy.

In order to explore this relationship, this study compares the attitudes towards female role and norms of four groups of women who, at the time of the study, differed in the ways they were managing their fertility. All four groups were composed of women who were dealing with the issues of birth control and/or pregnancy, but who had chosen to deal with the issue(s) in different ways. Group (1), "effective contraceptors," was composed of women who had effectively used contraception to avoid an unwanted pregnancy. Group (2), "initial abortion clients," was composed of women who had never before had an abortion, but who were choosing to terminate (abort) a current unwanted pregnancy. Group (3), "repeat abortion clients," was composed of women who were choosing to terminate (abort) a current

unwanted pregnancy and for whom this was at least a second (repeat) abortion. Group (4), "problem pregnancy carrying clients," was composed of women who had elected to carry a pregnancy to term after they themselves had defined it as a problem pregnancy or an unwanted pregnancy. The study compared the responses of these four groups to survey measures of four interrelated aspects of female role: (1) attitudes towards the rights and roles of women, (2) psychological androgyny, (3) attitudes towards sex and abortion, and (4) perceived work options.

This study assumes that an unwanted pregnancy is a personal and a social problem of considerable significance. Moreover, it assumes that pre-conception avoidance of an unwanted pregnancy (i.e., effective use of birth control) is more desirable than a post-conception solution to unwanted pregnancy such as abortion, or to bringing an unwanted child into the world. To the extent that this study is successful in demonstrating that there is a relationship between female sex-role in the direction of stereotypical traditional femininity, and unwanted pregnancy due to non-use or misuse of contraception, it will provide additional evidence regarding the costs to women and to society of the oppressive and destructive nature of the stereotypical sex-role socialization of women, as well as

suggesting a direction for effective education and counseling in the area of family planning and fertility management.

Review of the Literature

Scope of the Problem: The Extent and Costs of Unwanted Pregnancy.

The research on unwanted pregnancy and birth documents the personal and social cost of these occurrences. The "population bomb" and the costs of over-population are generally accepted as social problems of considerable magnitude (Hardin, 1968; Pohlman, 1969; Smith, 1973). The medical, psychological and social costs to women of manatory motherhood are well documented (Furstenberg, 1976; Rainwater, 1960, 1965; Trussell, 1976). Available data suggest that illegitimate children fare poorly in later life (Crellin et al., 1971; David, 1973; Dytrych et al., 1975; Forsman & Thuwe, 1966). The long-term effects of abortion on an individual have yet to be firmly established (Leach, 1977; Shusterman, 1976). Thus, it is generally conceded that fertility management and family planning serve both the individual and society.

Family planning agencies abound. It is the goal of these agencies to provide contraceptive services and family planning assistance to those who cannot afford or

do not choose to use the private sector to obtain such services. It is estimated that in 1972, more than 2.6 million women were served by such agencies at a cost of 56.8 million dollars (Jaffee, Dryfoos & Corey, 1973). By 1973, organized family planning programs were serving more than 3.2 million women (Weinberger, 1974). Over one billion dollars was set aside for research and the delivery of family planning services between 1971-1975. In other words, a massive attempt has been made to make contraceptive technology available to those who want it, and there is evidence that a sizable segment of the population is utilizing such services.

However, although there has been a fairly steady decline in marital fertility over the past eight years, there has been a concomittant rise in the rate of illegitimate births, particularly among teenagers. It is estimated that in 1971 there were 416,127 illegitimate births in the United States. On the basis of studies done in California, it has been asserted that this rate has continued to rise considerably over the past four years (Sklar & Berkov, 1974). Moreover at least 745,000 legal abortions were performed in the United States in 1973; by 1974 that figure rose to over 900,000 (Weinstock, Jaffee, Tietze & Dryfoos, 1975). Planned Parenthood of Greater Charlotte (PPGC) has performed an average of 200 abortions

per month over the last two years. In other words, in spite of the availability of contraception, a huge number of problem pregnancies and ostensibly unwanted pregnancies are conceived each year.

Theories Explaining Unwanted Pregnancy.

The phenomenon of unwanted pregnancy is a complex one. Although there is a sizable body of sociological literature concerned with population analysis, there is a relatively small body of psychological and social-psychological literature concerned with the causes and consequences of fertility and/or fertility management behavior.

Sociology has looked at population analysis primarily in terms of formal demography--i.e., the statistical study of human populations with reference to size and density, distribution, and vital statistics, as well as population theory, policies, and characteristics. It has not concerned itself with the dynamics of individual behavior, or with the ways in which a particular social setting motivates individual behavior (Fawcett, 1970; Freedman, 1975; Pohlman, 1969). Freedman (1975) noted that although there has been a surge of research in the last eight to ten years, there are still few empirical studies looking at psychological variables in a systematic way, and the progress in answering crucial research questions in the area of the psychology of fertility management has been limited.

Among researchers concerned with psychological explanations for fertility there are two traditional prevailing theories: contraceptive ignorance theory and intrapsychic conflict theory. More recently there has been some concern with looking at psycho-social variables as "intervening" variables and an attempt to explain how the social setting influences and motivates individual human behavior.

Contraceptive ignorance theory. This theory, generally stressing demographic factors and researched with survey techniques, asserts that lack of knowledge regarding contraception and/or the lack of availability of contraception are the causes of unwanted pregnancy (Bumpass & Westoff, 1970). The notion that contraceptive ignorance is largely responsible for a major portion of unwanted pregnancies dates back to the early part of this century. Fertility surveys and "KAP" (Knowledge, Attitudes, and Practices) studies have largely supported this notion (Fawcett, 1970; Pohlman, 1969).

Even though two of the major KAP studies--the Indianapolis Study (Whelpton & Kiser, 1946-1958) and the Princeton Study (Westoff, Potter & Sagi, 1963; Westoff, Potter, Sagi & Mishler, 1961)-- attempted to uncover psychological variables, neither showed significant correlations between psychological variables and indices related to fertility. The Indianapolis Study showed

"economic status" variables accounting for most of the differences between people in fertility behavior. The Princeton Study, in which an attempt was made to correct the methodological problems of the earlier study, focused on variables in three categories: socio-cultural environment, personal orientation towards various aspects of life situation, selected personality characteristics. However, as in the earlier study, no significant associations between psychological variables and fertility were disclosed. Fawcett (1970) cites Kiser (1967) in explanation of this fact:

> . . . (the Princeton Study's) failure to yield much association of psychological factors to fertility behavior suggests that the relevant psychological attributes either were not chosen or were inadequately measured.

Two of the major fertility surveys, the 1955 and 1960 Growth of American Families (GAF) Surveys (Freedman, Welpton, Campbell, 1959; Welpton, Campbell, Patterson, 1966), showed religion and education as important variables in relation to contraceptive practice.

The work of Kanter and Zelnik (1972, 1973), focusing on the sexual and contraceptive experiences of a representative national sample of adolescents, dominates the recent survey literature. Their work is considered significant both because of its scope and sophisticated design. They considered a wide range of variables, and while they

do not cite lack of contraceptive knowledge as the critical variable, they do cite ignorance of reproductive functioning and contraceptive technology as one of several important variables affecting the use and misuse of contraception among American teenagers, stating ". . . the extent of misinformation is substantial among all groups of teenagers examined" (Kanter & Zelnik, 1973).

Among family planning practioners, the notion that contraceptive ignorance is largely responsible for unwanted pregnancies has persisted (Luker, 1975). The vast majority of family planning agencies provides clients with a good deal of information about contraceptive technology and the correct use of contraceptive technology, along with whatever medical services are provided. Many agencies see this, the provision of contraceptive information, as the cornerstone of their educational and counseling programs.

However, Luker (1975) found that 86 percent of the abortion clients whom she interviewed had utilized contraception effectively at some time in their lives, and over half of these had used a prescription method. Although it is obviously imperative that contraceptive information and resources be made even more readily available, these statistics tend to cast doubt on the "contraceptive ignorance theory" as a <u>sufficient</u> explanation for unwanted pregnancy.

Intrapsychic conflict theory. This theory asserts that women get pregnant because they experience psychological resistance to using birth control. This school of thought is heavily influenced by psychoanalytic theory. Deutsch (1945) saw the problem pregnancy as motivated by the need to resolve oedipal conflicts. Devereux (1960) pointed to self-punitive impulses, and masochism as the unconscious causes of inadequate contraception. Blain (1967) cited the cause as conflicted sexual identity and the need to prove femininity. Lidz (1969) focused on the woman's possible conflicts over infertility, as well as the possibility of neurotic sexual adjustment and loss of control over sexuality, the possibility that a pregnancy provides a way of proving oneself and demonstrating potency, the possibility that the use of contraceptives was initiated only for financial reasons or to please a mate thus generating frustration or unhappiness, the possibility--for "the lonely, depressed, deprived woman"--that a pregnancy/child is a way of satisfying one's own emptiness, as plausible explanations for misuse or non-use of birth control. (In all fairness, it should be noted that the successful contraceptor does not fair much better in Lidz's view. By and large, the successful contraceptor is one who either has had several children and "feels finished with the job," or is fearful of pregnancy for any number of neurotic

reasons, or would rather be a man.) Lehfeldt (1971) pointed to psychological factors in what he called the "syndrome (of) willful exposure to unwanted pregnancy (WEUP)." He clarified that he means "willful" in the Freudian sense, in that it is neither rational nor conscious but betrays an emotional, unconscious need for pregnancy, due to psychological factors originating in either or both of the partners. Sandburg and Jacobs (1971) cited fourteen major psychological reasons why women misuse or reject contraception. In summary, they characterized the ineffective contraceptor as an immature, dependent, self-punishing individual, with low self-esteem, little desire to control her own life, and an inability to assume responsibility for self, control her own impulses, appreciate long range goals, or attain a good sexual adjustment.

In general, these studies are speculative rather than empirical in nature. For the most part, the conclusions drawn have been reached on the basis of the writer's clinical experience with a relatively small, skewed study population. (Not every pregnant woman chooses to see a psychiatrist or psychologist. Those who do, may well be choosing to do so because they are troubled rather than because they are pregnant.) It would seem fallacious to

attempt to generalize to a broader population from such a small sample population.

The research reviewed focuses heavily on intrapsychic phenomena and relies heavily on interpretation for its conclusions. It isolates the individual from the societal context in which she is acting. For the most part the only prescriptive, preventive or remedial approaches it suggests are long-term therapy for the individual to help her in overcoming her resistance to using birth control effectively; this solution is highly impractical and inefficient from the standpoint of family planning agencies. Thus this body of literature generates few intervention strategies of any practical assistance to family planning practioners. Finally, it is highly moralistic in tone and uniformly demeaning to women in that it depicts the problem pregnancy client as neurotic and deviant (mass deviance at that).

In recent years, moreover, several empirical sudies focusing on psychological variables have cast doubt on these findings. Barker (1967) found no differences in self-esteem between pregnant single women, pregnant married women, and non-pregnant single women. Lynch (1973) found no psychological differences between abortion clients and non-pregnant women on several scales, including the Rotter

Internal-External Scale, the Berger Self-Acceptance Scale, and a five question item pertaining to female reproductive activities.

Langer's (1975) work tends to contradict the work of the psychoanalytic theorists who propose that unconscious conflict or disturbance in sexual (gender) identity is related to motivation for pre-marital pregnancy and/or non-use of contraception. Langer's empirical study attempted to determine whether or not pregnancy is motivated and, if so, to assess the personality factors that might account for such motivation. The personality factors that she explored were: (1) motivation for motherhood, using a TAT based instrument she developed; (2) gender identity using the Franck Drawing Completion Test; (3) femininity using the Femininity (Fe) Scale of the California Psychological Inventory; and (4) sex-role style, using a nine item questionnaire related to the assertiveness-interdependence dimension of personal style (McClelland & Watt, 1968). Her study population consisted of 129 sexually active college women who were recruited through a psychology class. Her results were inconclusive. The only significant difference she found between contraceptors and non-contraceptors was on the sex-role style questionnaire: women using contraception were significantly more assertive than women who were not using contraception. In her

interpretation of this data she pointed out that (1) more "traditionally feminine" (interdependent) women tie sexuality to reproductivity and that the non-use or inconsistent use of contraception may well be an attempt to place themselves in a situation whereby those expectations could be met; and (2) it demands a certain amount of assertiveness for women, especially single women in temporary relationships, to obtain and use contraception. Langer (1975), however, made no attempt to explain the sex-role style differences in terms of sex-role socialization, or in terms of the social and cultural meanings of contraceptive use and pregnancy.

Langer's (1975) findings regarding the differences between contraceptors and non-contraceptors must be examined in terms of the societal context within which these women's behavior took place. As pointed out by Fawcett (1970), one of the great challenges facing psychologists in the field of family planning, is explaining the relationship between indivduals' economic and social situations and individuals' motivation. What psycho-social explanations can account for the ". . . differentials in fertility and fertility-related behavior that have been discovered in surveys, and account for shifts over time in such variables" (Fawcett, 1970)?

Psycho-social explanations for unwanted pregnancy: social-sexual role internalization. Rainwater's work (1960, 1965) is an attempt to develop psycho-social explanations for the fertility differentials that have been shown to exist between social classes. Rainwater considered the relationship of class, race, and religion to fertility, viewing conjugal role organization and marital sexual relations, family-size preference and motive, and contraceptive behavior as the intervening variables which affect fertility management.

He observed that successful fertility management is related to a variety of factors, including the degree of conjugal mutuality (as opposed to conjugal role segregation) as well as the degree to which the wife is accepting of her own sexuality and the couple enjoys a mutually gratifying sexual relationship. His findings led him to conclude that lower class women are typically less accepting of their own sexuality than more middle class women and that lower class marriages tend to be characterized by less mutually gratifying sexual relationships than their middle class counterparts. Moreover, he found that lower class marriages are more often characterized by role-segreated conjugal relationships than more middle class marriages. He noted that family-size preferences are, to some extent, related to a woman's dependence on the role

of mothering for her self-esteem, pointing out that lower class women tend to have fewer social and intellectual interests outside the home and see fewer alternatives to the wife-and-mother role, than do middle class women. He pointed out that effective contraceptive behavior is linked not only to the ease with which couples are able to communicate about sex and family planning, which is related to the degree of mutuality and sexual enjoyment they share, but also to the ability of the woman to assert herself. The findings, of this study, focusing as it does on marital and social role as intervening variables, clearly lend support to the notion that female sex-role is somehow related to effective fertility management behavior.

Several other recent studies have focused on the relationship of female role to fertility management behavior. On the basis of their review of the literature, Scanzoni and McMurry (1972) concluded that perceptions of female role do influence both family-size desire and contraceptive effectiveness. They noted that less traditional women will tend to stay single longer, desire fewer children, have a smaller completed family size and are more effective in limiting family size so that it is consistent with desired family size. Presser (1974) attributed ill-timed early motherhood to a combination of factors including knowledge and motivation. In her discussion of the

implications of her work, she indicated that she believes that the way to strengthen motivation to seek out and use contraception would be to change the patterns of the early socialization of women; in terms of implications for future research, she concluded that a logical next step would be to examine the relationship between the roles of women and the timing of the first birth and subsequent fertility. Klerman (1975) speculated that four problems in particular impact on youth and lead to adolescent pregnancy: (1) lack of societal purpose, (2) lack of meaningful work, (3) narrow definitions of the female role, and (4) a lag between actual sexual practices and society's moralistic attitudes towards sexual practices, which make it difficult for young women to obtain and use contraception. Her hypotheses demand empirical support.

The work of Miller (1973, 1974) is particularly relevant to this study. The first of the two studies cited focused on development of an assessment instrument (used in this study) designed to fill two needs:

> The first is a need for valid psychological assessment instruments which can be used in investigations with large samples or where the prospective subject's time is limited, such as in a busy clinic. The second is a need for more complete understanding of the role of sexuality variables in the variance of fertility (Miller, 1973).

His hypotheses are quite consistent with the hypotheses of this study. In discussing the ways in which

sexuality variables are related to fertility management behavior, Miller conjectured that the woman at greatest risk of unwanted pregnancy would be a woman who experiences a high degree of ambivalence regarding her sexuality, achieves little satisfaction from sex and indulges in sexual interaction for non-sexual reasons such as compliance, lack of assertiveness, or affection getting. Also at considerable risk would be a woman with traditional values about femininity, who rejected her own sexuality and possessed moralistic attitudes towards sex. At least risk, he suggested, would be a woman with a relatively liberal and modern stance regarding female values and sexual values, who accepts her own sexuality and, consequently, is able and willing to plan on and prepare for sexual encounters. He noted that these hypotheses were supported by correlations he found between criterion groups and number of children desired: traditional women desire more children than do liberal-modern women who have characteristics that correlate with low fertility, such as higher level of education, career objectives, and small family-size desires. These hypotheses remain to be tested empirically.

Miller's (1974) work exploring the relationship between female role orientation and reproductive behavior posits that a woman's perception of adult female role is linked

in significant ways to her reproductive career. The paper cited is the initial (one-year) report of a five-year prospective investigation using the "Feminine Interest Questionnaire," which he himself developed; Miller surveyed the responses of 967 "never-married," "just married," and "just-mothered" women. His findings, though inconclusive, suggest that, in general, a more modern orientation towards female role is associated with later marriage and a desire for fewer children. Though his findings show only a weak association between female role orientation and adequacy of pre-marital contraceptive use, the relationship which does exist suggests that women with a more modern orientation do tend to be somewhat more effective contraceptive users. In explaining this, Miller notes that he--like other researchers--has found "contraceptive behavior is one of the most consistently difficult types of behavior to predict and explain with any adequacy." Nonetheless, his findings do "affirm the overreaching importance of gender role orientation as a key variable for understanding reproductive sentiments and behavior" (Miller, 1974). This line of inquiry is obviously worth pursuing.

Kristin Luker's (1975) work deals directly with the issues of contraceptive use and contraceptive risk taking. She posited that contraceptive risk-taking is the end result of a dynamic decision-making process, employed by women who

are both informed and rational. Luker described her work as a pilot study, a preliminary investigation designed to generate (rather than validate) hypotheses about problem pregnancy and contraceptive use/misuse. To this end she used the "grounded theory approach of Glaser and Strauss," conducting open-ended, relatively instructured interviews with abortion seeking women. From these interviews emerged the coding categories that she later called "costs of contraception" and "benefits of pregnancy." Her hypothesis is that women who choose to take contraceptive risks do so on the basis of a cost-benefit accounting, comparing the costs and benefits of using birth control against the costs and benefits of possible pregnancy. Given the societal context in which they make this decision, she said, it is a rational one.

The social and cultural costs of using contraception cited by Luker are directly related to the extant definition of female sex-role and norms for role appropriate behavior. In order to use birth control effectively, a woman must break a good number of the rules for sex-role appropriate behavior. The woman who uses contraception is taking an active stance in managing her own sexuality and reproductivity. She is acknowledging that she is planning intercourse. She is actively disassociating her sexuality from her reproductive functions. Clearly, this

is norm breaking behavior, especially for single women. Moreover, the benefits of pregnancy, identified in Luker's study, are sex-role specific. Pregnancy is a way of proving femininity, or womanliness. Pregnancy is a way of establishing that one is capable of producing children, thus that one is a normal, worthwhile woman who is capable of performing the function (producing children) for which this society rewards women.

Luker, herself, pointed out, however, that the purpose of her study was to generate hypotheses, not to test or validate those hypotheses. While her explanations of contraceptive risk-taking behavior make perfect intuitive sense, they remain to be tested.

In summary, there appear to be three general explanations of problem pregnancy: (1) it is caused by lack of information or lack of availability of resources ("Contraceptive Ignorance"); (2) it is the result of intrapsychic motives in women ("Intrapsychic Conflict"); and (3) it is a rational decision made in the context of social roles and the demands imposed upon us, through those roles, by our society and our culture (Social-Sexual Role Internalization). While there may be some truth in each of these interpretations, only the first two have been stressed. To date, active steps to intervene in the problem of unwanted pregnancy have been based on these

first two points of view. This dissertation explores this third hypothesis. Does empirical data support this point of view? Does it appear to have practical value in terms of its implications for action?

Purpose of the Study

The primary purpose of this study is to extend the present state of our understanding of how women's fertility management behavior is related to perceptions of female sex-role and perceptions of norms for role appropriate behavior. In particular this study is an exploratory attempt to identify what proportion of variance in fertility management behavior is accounted for by sex-role related variables, i.e., internalized aspects of the female social-sexual role, in contrast to contraceptive knowledge. Ultimately, it is to be hoped, the findings of this study will provide useful data for family-planning practitioners in their attempts to assist the individuals who seek their help in fertility management.

Internalized Aspects of the Female Social-Sexual Role

This study asserts that women's attitudes towards themselves as women, their perceptions of female role and role appropriate behavior, and their perceptions of the

work options available to them as women influence their effectiveness as contraceptors.

Women are taught to see themselves in certain ways; they are taught what is appropriate and inappropriate behavior; they are taught that only certain, limited options are available to them. From earliest childhood on, at home, at school, in all cultural institutions (e.g., church), women receive messages about what it means to be a woman. Female children are treated differently than male children (Block, 1973). Different behaviors are expected. Different behaviors are rewarded. Women's attitudes towards themselves are a function of this training, this process of socialization.

While notions about female-role and role-appropriate behavior vary within the subcultures of class, ethnic group, and race, there does seem to be a fair level of consistency in perceptions of the idealized, traditional female role across these lines (Rainwater, 1965). Nonetheless, it must be noted that "female-role" as it is described here is, in general, the "female-role" as it is proscribed by the dominant white, middle class culture.

The traditional female role demands of women that they exhibit essentially the very same behaviors and qualities that Sandburg and Jacobs (1971) consider to characterize the ineffective contraceptor: immature,

dependent, self-punishing, with little desire to control her own life, and an inability to assume responsibility for self or control her own impulses, appreciate long range goals, or attain a good sexual adjustment. Traditionally, femininity has been associated with an "expressive orientation" as opposed to an "instrumental orientation" (Parsons & Bales, 1955), a "communal orientation" as opposed to an "agentic orientation" (Bakan, 1966), as concerned with "inner space," as opposed to concern with the world or "outer space" (Erikson, 1964). The traditional female role demands of women that they be passive rather than assertive, emotional rather than rational, impulsive rather than practical, concerned more with nurturing others than with their own needs, concerned more with peace-keeping than with standing up for themselves. Women are taught that their proper domain is the home, certainly not the "outer" world.

The successful utilization of birth control demands that women break the traditional rules of role appropriate behavior. There are four aspects of traditional female role that are particularly pertinent to an examination of contraceptive use by women. These are their (1) attitudes towards the rights and roles of women in contemporary society, (2) psychological androgyny, (3) attitudes towards sex and abortion, and (4) perceived work options.

The Rights and Roles of Women.

The ideal young woman has been taught, since early childhood, to look forward to getting married and being a mother. Marriage is treated as the long term goal for which every young woman aspires. The woman who, for whatever reasons, does not marry is likely to see herself as a "failure," as well as being seen as a "failure" by many of those around her. Moreover, the idealized woman is depicted as having powerful maternal instincts. She is a nurturer, a caretaker. She has been taught from earliest childhood that her function is to nurture. Traditionally, motherhood is venerated in our society. Women are valued for their fertility. The woman who is infertile is somehow not normal. To a tremendous extent, women are taught to value themselves primarily as potential wives and mothers. It is the rare girl-child who does not someday plan to be a "mommy."

While a more modern orientation towards female-role does allow for careers outside the home and does depict women as having a broad range of social and intellectual interests beyond home-making, the wife-and-mother role still seems to occupy a central position in notions about female role. Moreover,

> . . . if the wife works outside the home (and as a matter of fact many women do work, most because of financial need), her work outside is always considered

> secondary to her responsibilities in the home. . . . Even in professional dual career families, . . . it is almost invariably the woman who is responsible for making provisions that make it possible for her to leave the house . . . she continues to be responsible for the ongoing maintenance functions of the family, . . . and in general facilitating the human relations in the family (Appley, 1977).

At the same time, in the work world itself, women are still viewed as possessing fewer rights than their male counterparts.

> . . . when men and women interact in organizations they tend to do it across status lines in which power, leadership, decision making and control are considered male functions; and support nurturance, hostessing and organizational housework are considered female functions.
>
> . . . Males have generally higher status and power in American society than females, so that when men and women are ostensible peers, the male's external status may give him an advantage inside the group . . . in a group of men there is pressure on (a woman) to adopt one of four stereotypical roles: mother, sex object, pet, or "iron maiden". . . . Such roles help the men confine the woman to a limited place, where she is not a competitive threat and her sexuality is comfortably defined in traditional ways . . . if (a woman) insists on full rights in the group, displays competence in a forthright manner, or if she cuts off sexual innuendos, . . . she may henceforth be regarded with suspicion . . . and with distance, for she is demanding treatment as an equal in a setting (in which women are not viewed as equal) (Kanter, 1977).

Clearly, then, the rights and roles of women are circumscribed. It is not particularly surprising that many young women grow up with narrow definitions of female role and narrow perceptions of role-appropriate behavior.

Psychological Androgyny.

To be androgynous is to have available to oneself the strengths, qualities, and behaviors that are considered feminine, as well as the strengths, qualities and behaviors that are considered masculine. Thus, in situations which demand strength or assertiveness, the androgynous woman behaves strongly or assertively, not unlike the androgynous man. In situations which demand tenderness, the androgynous man reacts tenderly, not unlike the androgynous woman. In other words, the androgynous human being transcends rigid sex role stereotypes, and is capable of incorporating and integrating qualities typically seen as masculine with qualities typically seen as feminine.

Whereas, the traditional "feminine" woman has been trained to be passive, the androgynous woman is capable of being either passive or assertive as the situation demands. As Langer (1975) pointed out, it demands a certain amount of assertiveness for a woman to acquire and use birth control. In other words, the more androgynous woman, who is capable of being assertive when the situation calls for assertiveness, is likely to be a more effective contraceptor than the woman who has been trained never to be assertive. The traditionally feminine woman, trained to be demure, passive, submissive and unattainable has been trained not to use birth control effectively.

Sexuality.

The idealized female role depicts women as sexually yielding but certainly not as overtly interested in sex, affectionate but not sexy; submissive and passive rather than aggressive; demure, and somewhat unattainable. The traditional dichotomized view of women as either "bad women" or "good women" persists, especially and most strongly among the lower socio-economic classes (Rainwater, 1965). "Good women" do not plan or calculate for sexual encounters. Consequently, it may be very difficult for "good women" to utilize contraception, because that demands not only acknowledging (to self and to partner) that one had planned sexual activity, but it is also an acknowledgement of one's sexual availability, making one less "unattainable" and thus less valuable.

There are several factors in contemporary society, however, that confound the picture considerably for women. One factor is the mixed message that women receive about their femininity and sexuality. First, not only are women supposed to be demure and unattainable (or at least a challenge), they are also, supposed to be sexy and desirable. "Sex appeal" is touted daily on T.V., in popular music, in magazines, in films as the one attribute that all women should strive to attain. Not only are women supposed to be sexually passive, they are also exhorted to be fascinating

and exciting sexual partners, lest they lose their men. Whereas the ideal woman is anything but sexually aggressive, the media model for the successful woman (i.e., the woman who is able to get what she wants) is a coy and seductive one. Thus, in order to be a "real woman," one almost has to be sexy. At the same time, in order to be an "ideal woman" one has to deny one's sexuality. At best, it is difficult to take responsibility for an aspect of self that one denies. This dilemma can be resolved or endured in a number of ways.

Secondly, as Luker (1975) points out, changes in the role of courtship and in the value of marriage as an institution, changes in notions of accountability and responsibility for males and females in the sexual and reproductive spheres, and advances in contraceptive technology have had a tremendous effect on contraceptive use in the past two decades. With the advent of the pill, responsibility for birth control has come to rest with women; if a woman gets pregnant it is "her own fault" since she could have done something to avoid it. The legalization of abortion has extended the sphere of responsibility for women. Now, if a woman gets pregnant because she was not using contraception, she can get an abortion. If she chooses to carry the pregnancy to term rather than terminate it, the responsibility for raising the child is hers alone, since she could

have terminated the pregnancy and chose not to do so. This presents a variety of problems for both men and women. Women are held completely accountable for what is by definition a mutual act; men are denied a role in mutual decision-making regarding the use/non-use of contraception, as well as the decision whether or not to terminate an unplanned pregnancy. Finally, as Luker (1975) pointed out, women have lost their bargaining power for marriage, largely as a result of the so-called "sexual revolution" and the availability of sex outside of marriage. Nonetheless, women must still depend on marriage for status and economic security, since other economically and socially rewarding alternatives are not as available to them. This too has had an impact on contraceptive use. For pregnancy might well lead to marriage; if nothing else, it does provide an opportunity to test the partner's degree of commitment.

Work Options.

In terms of both work options and social options, the surest route to social and economic status is marriage. Women have few socially approved alternatives to marriage and motherhood. The alternatives they do have do not pay very well. "Full time women workers in 1968 earned 58 percent of the income of full time male workers. Moreover the income differential actually increased between 1958 and 1968" (Luker, 1975). Moreover, women are under represented

in all the major professions: in the U. S. "they comprise 6 percent of the doctors, 3 percent of the lawyers, 22 percent of the academics, and 6.3 percent of upper echelon business executives" (Luker, 1975). The ideal woman--non-competitive, emotional rather than rational, passive rather than assertive, nurturing rather than self-aggrandizing--has been trained not to "make it" in the "outer" world, anyway. Clearly, marriage and motherhood are the best jobs available to her. Thus, women's perception of themselves as having few options other than marriage and motherhood is neither neurotic nor an indicator of psychological problems. It is an accurate perception of reality and a reflection of the status of women in society. It is reasonable to assume that until this situation changes and there are more viable high-status, economically-rewarding options open to women, women will continue to opt for marriage and motherhood.

Given all the conflicting demands of the female sex-role, contraceptive misuse or non-use is quite comprehensible. Nor is it necessary to label the non-contraceptor (the woman who is risking a problem pregnancy), as pathologically deviant or neurotic. She is simply responding to the plethora of cultural messages with which she is--and has been all her life--bombarded. This study posits that the degree to which a woman has internalized

the traditional conception of the female role, particularly as it relates to female sexuality and to the valuing of herself primarily as a wife and mother, will have an inverse relationship to her effectiveness as a contraceptor. To the extent that women perceive no other options for themselves, they will choose pregnancy. To the extent that their sense of themselves as worthwhile human beings is dependent upon their ability to fulfill the role of wife and mother, they will continue to attempt to test their fertility and to prove their credentials for that role. To the extent that they are educated to believe that the appropriate female role in sexual matters is a passive, coy, and reactive one, they will continue to behave passively, coyly, and reactively. In other words, in order for women to behave differently, they must be given an opportunity to examine and redefine the female role.

Significance of the Study

This study is concerned with extending the present state of understanding of the phenomenon of unwanted pregnancy, which is a personal and social problem of considerable magnitude. The major premise of the study is that effective fertility management behavior is directly related to women's perceptions of female role and norms for role appropriate behavior. To the extent that this study is

successful in documenting this relationship and thus explicating the causes of unwanted pregnancy, it will be of assistance to family planning professionals in three different ways.

First, it would suggest diagnostic instruments which could be used to identify women who, given their current definitions of female role, are potential contraceptive risk-takers, in need of preventive intervention if they are to avoid future unwanted pregnancies. Secondly, it would enable those who counsel the problem pregnancy client to assist that client in understanding how her problem came about. It would, in fact, open to exploration and analysis contraceptive risk-taking behavior. Finally, for those concerned with preventive education, it would suggest radically different guidelines for educational programs. Currently, such programs focus almost entirely on providing information on the various methods of contraception currently available and how to use those methods. This study will suggest that such programs would be more effective if they were designed not only to provide information but also to enable women to examine their ideas and beliefs about female role, both in terms of their attitudes towards their own sexuality and their ability to see, prepare for, and demand socially and economically rewarding alternatives to marriage and motherhood.

Moreover, this study contributes new data on the specific costs to women and to society of the stereotypical sex-role socialization and oppression of women. This data should prove useful to the social scientists who are attempting to understand the impact of sex-role socialization on human behavior, and should be a valuable contribution to the growing body of literature on that subject.

Outline of the Dissertation

Chapter II describes the methods used to explore the premises of this study. The research design, study sample, instruments used, and statistical analysis employed are described in depth.

Chapter III reports and discusses the findings of this study in terms of the specific null hypotheses postulated.

Chapter IV contains the conclusions and implications of the findings of this study. It also contains recommendations for future research in the area of fertility management, and suggestions for family planning practitioners. Finally, it relates the findings of this study to the current social-political situation and recommends some specific social-political arenas for action.

CHAPTER II

METHODS

The aim of this research is to provide an exploratory test of the premise that women's perceptions of female sex-role definition and the norms for role appropriate behavior are related to their contraceptive behavior. This chapter will (1) clarify and expand upon this premise and state the specific hypotheses of this study; (2) define the terms being used in this research; (3) describe the sample population; (4) describe the procedures used to gather the data; (5) describe the measures used to test the hypotheses of this study; and (6) describe the statistical tests used to analyze the data.

1. Hypotheses.

The primary premise of this study is that there is a relationship between women's perceptions of the female sex-role and norms for role appropriate behavior and their behavior as contraceptors. More specifically, a direct relationship is predicted between the degree of pro-feminist views and the degree of success in managing fertility and avoiding an unwanted pregnancy. Further, it has been predicted that four interrelated aspects of perceived

female role are particularly important: (1) attitudes towards the rights and roles of women in contemporary society; (2) psychological androgyny; (3) attitudes towards sex and abortion; and (4) perceived work options. In other words, women who are more pro-feminist on these four aspects will be more successful in using birth control to avoid an unwanted pregnancy than women with more traditional views about female roles and norms. Women who are in the throes of experiencing an unwanted pregnancy are likely to hold more traditional views regarding the female sex role, as defined by the four interrelated aspects named above, than women who successfully used contraception to avoid an unwanted pregnancy.

In order to explore this premise, this study compared the attitudes toward female roles and norms of four groups of women who, at the time of the study, differed in the ways they were managing their fertility. All four groups were composed of women who were dealing with the issues of birth control and/or pregnancy, but who had chosen to deal with the issue(s) in different ways. Group (1) was composed of women who had effectively utilized contraception to avoid an unwanted pregnancy. Group (2) was composed of women with unwanted pregnancies who were choosing to terminate those pregnancies by abortion. Group (3) was composed of women who were choosing to terminate unwanted pregnancies by abortion

and for whom this was at least a second abortion (repeat abortion). Group (4) was composed of women who had elected to carry a pregnancy to term after defining it as a problem pregnancy, and who were seeking help from a community agency in dealing with the pregnancy.

The predicted direction of this difference is that Group (4) would have internalized the traditional female role most completely, and Group (1) would have internalized the traditional female role least completely. In other words, to confirm this study's premise the data will show significant differences between each of the four groups, with Group (1) being the most pro-feminist, Group (2) being somewhat less pro-feminist, Group (3) being much less pro-feminist than Group (1), and Group (4) being the least pro-feminist group of all.

Each of these four groups responded to survey measures of (1) attitudes towards the rights and roles of women in contemporary society; (2) psychological androgyny; (3) attitudes towards sex and abortion; and (4) perceived work options. The hypotheses of this study are confirmed to the extent that there are statistically significant differences among the four groups on the survey measures, showing that the more effective the contraceptor group, the more pro-feminist are their attitudes. Or, conversely, this study is designed to provide evidence that the women most likely to

exhibit contraceptive risk-taking behavior will be those women who have most completely internalized the traditional definition of the female sex-role and the norms for role appropriate behavior.

2. Definition of Terms.

The working definitions of the key terms used in this study are as follows:

Sex-Role - The constellation of qualities an individual understands to characterize males and females in his/her culture. By direct implication, an individual's conception of sex roles will influence in important ways both behavior and self-evaluation (Block, 1973).

Problem Pregnancy - Any pregnancy that is defined as problematic by the pregnant woman for any reasons: the so-called problem may be financial (no money to support a child), emotional (lack of readiness for child-bearing/child-rearing), physical (ill-health of mother, or suspected health problems of fetus), relationship oriented (the partner does not wish to have a child right now, and the pregnant woman does, or vice versa), family oriented (the woman's parents and/or

significant others cannot accept her pregnancy, whereas she does, or vice versa), or concern with out-of-wedlock birth and the social sanctions that entails. A problem pregnancy may or may not be terminated.

Unwanted Pregnancy - For purposes of this study, operationally defined as any pregnancy which is terminated (aborted).

Effective Contraceptor - A woman who uses birth control to successfully avoid pregnancy when she does not wish to become pregnant. For purposes of this study, a woman will be considered an effective (successful) contraceptor if

1. Has been sexually active for at least two years.
2. Has not had more than one unwanted pregnancy or abortion in her lifetime and has not had any unwanted pregnancies or abortions within the last two years.

3. Has used an "acceptable" method of birth control (pill, IUD, diaphram, foam, condoms, foam and condoms in combination), consistently over the past two years. Consistent use of contraception means no more than one pill per month had been skipped, IUD is in place, or mechanical methods had been employed during <u>every</u> sexual encounter, except <u>during</u> menses. "Rhythm" will be considered an acceptable method of birth control only if the woman is using it in conjunction with keeping a basal temperature chart to determine time of ovulation.

Ineffective Contraceptor - Any woman who--in spite of the fact that she claims she does not want to have a child--either does not use contraception or uses it inconsistently and becomes pregnant. For purposes of this study, only abortion-seeking women (i.e., woman experiencing an unwanted pregnancy) who did not use contraception during the month prior to conception, will be considered ineffective

contraceptors. Women who are pregnant due to "contraceptive failure" will be excluded from this group.

Contraceptive Failure - Failure of the method, rather than the woman. Women who become pregnant with an IUD in place, or in spite of having used a mechanical method consistently, or in spite of having missed no more than one pill per cycle, can be described as pregnant "due to contraceptive failure."

Abortion - Induced termination of a pregnancy. Spontaneous abortions or miscarriages will not be considered abortions for purposes of this study. Also, this study will only include women who terminate their pregnancies during the first trimester at Planned Parenthood of Greater Charlotte.

Repeat Abortion - An abortion is considered a repeat abortion if it is the second abortion a woman has had in her lifetime. Some women report as many as four or five abortions. The validity of this classification is largely dependent upon truthful disclosure of the abortion client.

Abortion Client - A woman who comes to PPGC to obtain an abortion. Only women who do, in fact, terminate their pregnancies will be considered "abortion clients."

Contraceptive Client - A woman who comes to PPGC to obtain birth control. Only women who meet the criteria for an "effective contraceptor" will be considered as "contraceptive clients" for the purposes of this study.

Carrying Client - A woman who is pregnant and has chosen to <u>carry</u> the pregnancy to term, in spite of the fact that she herself has defined the pregnancy as a "problem" and/or indicated that it is an "unwanted" pregnancy.

For purposes of this study only women who are (1) in residence at the Crittendon Home for Unwed Mothers or (2) in attendance at the Charlotte Memorial Hospital Problem Pregnancy Clinic will be considered as "carrying clients." (Note: Not all women at the Problem Pregnancy Clinic are included in this group. Only women between the ages of eighteen and thirty are included. Also, the social workers at Charlotte Memorial Hospital screened clients at the Problem Pregnancy

Clinic, so as to include in the study _only_ women who _themselves_ defined the pregnancy as "a problem" or "unwanted" at the time of the initial interview.)

5. _Sample_.

Survey responses were obtained from a total of 120 women, that is thirty women in each of the four relevant categories: effective contraceptors, abortion clients who had never before had an abortion, repeat abortion clients, and carrying clients. This sample was drawn from among the clients of three Charlotte, North Carolina, agencies.

The study was conducted over a three-month period, November, 1976, - February, 1977. The three Charlotte-based agencies that participated in the study were Planned Parenthood of Greater Charlotte, the Florence Crittendon Home for Unwed Mothers, and the Social Services Department of Charlotte Memorial Hospital. The staffs of all three agencies were advised of the nature and purposes of the study and volunteered their participation. Contacts with the women included in the study population were made through the staff members of the participating agencies.

Ninety (90) of the subjects were obtained through Planned Parenthood of Greater Charlotte. Of these, thirty (30) were contraceptive clients, thirty (30) were abortion clients, and

thirty (30) were repeat abortion clients. The remaining thirty (30) subjects were women who had chosen to carry their pregnancies to term: fourteen (14) of these subjects were in residence at the Crittendon Home for Unwed Mothers and sixteen (16) were in attendance at the Charlotte Memorial Hospital Problem Pregnancy Clinic.

Survey packets, containing all the measures used in the study, were administered to the first thirty women in each category who indicated a willingness to participate in the study. Sample selection was cut-off as soon as thirty completed packets had been obtained from women who met the criteria for each particular group.

Insert Table 2:1 about here

A comparison of background characteristics raises a question as to whether or not the four groups are, in fact, comparable. Whether or not the four groups are truly comparable does have implications for analysis of the results. An appraisal of the above table makes it obvious that there are potentially significant differences among the four groups on at least four of the background characteristics: marital status, race, level of education achieved, and job status. If the four groups do vary significantly in terms of these background characteristics, it would be possible to assert

TABLE 2:1

NUMERICAL SUMMARY OF THE INDIVIDUAL CHARACTERISTICS OF THE STUDY POPULATION

	Group 1	Group 2	Group 3	Group 4	Total Sample
Age Range	19-30	18-33	17-32	18-32	17-33
Median Age	22	22	21	21	22
Married	11	5	2	4	22
Single (never married)	15	17	23	19	74
Separated	2	4	1	4	11
Divorced	2	3	4	3	12
Widowed	0	1	0	0	1
White	23	22	29	13	87
Black	6	8	1	17	32
Other	1	0	0	0	1
Protestant	22	24	21	25	92
Catholic	2	1	1	2	6
Jewish	0	0	0	0	0
Other	2	2	2	0	6
N/R	4	3	6	3	16
Elementary	0	0	1	0	1
H.S.	9	15	12	25	61
College	19	14	17	5	55
Graduate	2	1	0	0	3
Student	14	6	10	4	34
Non-Student	16	19	18	25	78
N/R	0	5	2	1	8
Unemployed	8	11	9	18	46
Blue Collar	5	6	8	7	26
White Collar	16	12	12	5	45
Professional	1	1	1	0	3

that differences among the four groups in responses to the measures are related to differences in background characteristics, as opposed to criterion differences in the groups. Thus, in an analysis of the results, it will be necessary (1) to establish whether or not these differences are statistically significant and (2) whether or not the dependent variables explain group membership after these demographic differences have been controlled or partialed out.

Unfortunately, no data regarding the number of children a woman has had, reproductive history, contraceptive history, or whether or not she was currently seeking contraception are available. Although a "Counselor's Sheet" calling for that data was designed to be filled out by those administering the survey packets and attached to the packets, these single sheets were often not attached to the survey packets, and total scores on these dimensions could not be computed. Thus, for all intents and purposes these data were lost to the study, and the contribution of these potentially relevant variables cannot be determined.

4. Survey Administration Procedures.

The surveys were administered to the subjects at all three agencies as part of the agencies' admitting procedures and prior to any counseling sessions. All subjects were told that the research was being conducted by the agency

> . . . in order to improve our services and be sure that our services fit the attitudes and needs of our clients. To do this we need to know more about how our clients feel about a variety of different topics.

Subjects were assured that their responses to the questionnaires would be completely confidential. Each subject was supplied with a manila envelope into which she could place the completed packet. Subjects were told that after they completed filling out the questionnaires, they would have an opportunity to discuss the research instruments and/or their responses to the questionnaires with their counselors, if they should desire to do so. Participation in the research was strictly voluntary; subjects were asked if they would be willing to fill out the packets and told that they were free <u>not</u> to do so. No tally was kept of the number of people who chose not to participate. Nonetheless, the staff members of the three participating agencies reported that few if any women refused to participate.

Similar procedures were used for collecting data from all four groups. As previously indicated, ninety (90) of the 120 subjects included in the total sample were obtained through Plannned Parenthood. The first thirty (30) women to meet the criteria for each of the first three groups -- Group (1) effective contraceptors, Group (2) abortion clients, Group (3) repeat abortion clients -- accounted for the ninety (90) respondents obtained through Planned Parenthood.

It is standard procedure at Planned Parenthood for every client to be seen by an interviewer or counselor, for purposes of ascertaining a complete medical history, prior to receiving any medical services or subsequent counseling services. Thus it was relatively easy for counselors/interviewers to screen women at the time of this initial interview for participation in the study. In order to facilitate distribution, collection, and coding of the surveys, different color packets were distributed to subjects in each of the three groups. Effective contraceptors (Group 1) were given blue packets. Abortion clients (Group 2) were given yellow packets. Repeat abortion clients (Group 3) were given pink packets. Approximately half an hour was set aside for completion of the survey. An individual interview-room was provided so that respondents would have both quiet and privacy during the time it took them to complete the survey.

As previously indicated, the subjects included in Group (4) were obtained from the other two participating agencies, the Crittendon Home for Unwed Mothers, and the Social Services Department of Charlotte Memorial Hospital. Subjects included in Group (4) filled out white packets. At Crittendon, administration of the research packet was treated as a normal part of intake for women between the

ages of eighteen and thirty. Nonetheless, as at Planned Parenthood, prospective subjects were advised that participation was optional and that they had the right to choose not to fill out the questionnaire. The intake worker at Crittendon reported that there were no refusals to participate. The questionnaire was administered within twenty-four hours of admission and prior to the time that the subject began participating in any of the activities (counseling, educational, or recreational) in which residents normally participate. After completion of the survey, the intake worker made herself available to subjects to discuss any questions or concerns generated by the experience of filling out the packet. A total of fourteen (14) questionnaires was collected from Crittendon residents.

At Charlotte Memorial Hospital, a social worker routinely interviews clients coming to the Problem Pregnancy Clinic for the first time. Thus, it was relatively easy for the social worker to administer the research packet at the time of the subject's initial visit to the clinic. Again, as at the other two agencies, participation in the study was stricly voluntary. At Charlotte Memorial Hospital, the screening function provided by the social worker was particularly important, since the Problem Pregnancy Clinic at the hospital was set up to handle all pregnancy-related problems and not unwanted pregnancies in particular. However, all

the subjects included in this study had specifically indicated that they had neither planned nor wanted to be pregnant at this time, and that, in fact, they considered being pregnant a "problem," in spite of the fact that they intended to carry the pregnancy to term. Only women who volunteered this information at the time of the initial interview were included in the study sample. They were asked to complete the surveys prior to any subsequent counseling. A total of sixteen (16) questionnaires was collected from subjects in attendance at the Problem Pregnancy Clinic.

A final important fact to note about the Charlotte Memorial Hospital Problem Pregnancy Clinic is that it has relatively strict eligibility requirements. In order to qualify for the clinic, a person must be a Mecklenburg County resident who either qualifies for Medicaid or Aid to Dependent Children or who makes an income that does not exceed a certain ceiling. Income eligibility is computed on the basis of the number of people in the family. In other words, the clinic serves an indigent or near-indigent population. Although both other agencies use sliding fee scales and provide financial assistance to those without funds to pay for services, neither has an income ceiling or eligibility requirements.

5. Measures.

In order to explore the predictions of this study, specific instruments were selected or developed to measure [A] the four interrelated aspects of the female sex role -- (a) attitudes towards the rights and roles of women in contemporary society, (b) psychological androgyny, (c) attitudes towards sex and abortion, and (d) perceived work options. In addition to the principal measures, each subject completed [B] two background data questionnaires -- (a) a shortened form of Miller's (1975) "Sexual and Contraceptive Knowledge Questionnaire" and (b) a "Personal Data Sheet," designed to gather individual background data considered potentially relevant in influencing the findings on the principal measures.

[A] ASPECTS OF FEMALE SEX ROLE ATTITUDES

(a) Attitudes Towards the Rights and Roles of Women in Contemporary Society

In order to assess attitudes towards the rights and roles of women in contemporary society, the short version of the Spence-Helmreich (1973) "Attitudes Towards Women Scale" (AWS) was used. This is a twenty-five-item Likert-type scale containing statements about the rights and roles of women. "Each item is

given a score from 0 to 3, with 0 representing the most traditional and 3 the most contemporary, pro-feminist response" (Spence, Helmreich, Stopp, 1973).

A complete copy of the shortened version of the AWS is included in the appendix. Nonetheless, the first three items are here included, to further familiarize the reader with the instrument and its format.

Swearing and bad language are worse in the speech of a woman than a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Both husband and wife should be allowed the same grounds for divorce.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

When factor analyzed,

> . . . the scale proved to be unifactorial, with the first unrotated factor accounting for 67.7 percent of the variance for females and 69.2 percent of the variance for males (Spence, Helmreich, Stopp, 1973).

The short form correlates highly with the long form: .968 for males, .969 for females. The original (long) form was developed on a college population:

> the AWS was given to 420 men and 529 women in several classes in introductory psychology at the University of Texas in Austin during the fall semester of 1971 and to 293 men and 239 women in several classes during the spring semester of 1972 (Spence and Helmreich, 1972).

Statistics from the two samples indicate that distributions for the two semesters are similar, particularly for the women. In addition to data on students, 292 mothers and 326 fathers of students were tested, so as to establish normative data on an older population. The scores of the older group tended to be more conservative, as predicted, than those of the students, although in both groups the mean score for women was significantly higher (more liberal) than the mean score for men. Correlations with the self-rating scales of the Personal Attributes Questionnaire (PAQ), though small, are logically coherent.

> Males who are high in masculinity on the male-valued scale tend to be more conservative in their attitudes toward the equality of the sexes. Similarly, women who are more feminine on the female-valued scale . . . also tend to advocate conservative

> views about sex roles (Spence, Helmreich, Stopp, 1975).

There are two major limitations of this scale. One is the limited data regarding validity. The second is that it was developed on a fairly homogenous population: college students and their parents. The language is somewhat sophisticated for a general population.

(b) Psychological Androgyny

The Bem Sex Role Inventory (BSRI) was used to assess degree of androgyny. This is a sixty item scale, including both a masculinity scale of twenty items and a femininity scale of twenty items, as well as twenty neutral items.

> The BSRI characterizes a person as masculine, feminine, or androgynous as a function of the difference between his or her endorsement of masculine and feminine personality characteristics. A person is thus sex typed, whether masculine or feminine to the extent that this _difference_ score is high" (Bem, 1974).

The closer the androgyny score is to zero, the more androgynous the individual.

A complete copy of the BSRI, as it was presented in the survey packet, is included in the appendix. The following table lists the items as masculine, feminine, or socially desirable (neuter).

TABLE 2:2

ITEMS INCLUDED ON THE BEM SEX ROLE INVENTORY

Masculine	Feminine	Socially Desirable
Acts as a leader	Affectionate	Adaptable
Aggressive	Cheerful	Conceited
Ambitious	Childlike	Conscientious
Analytical	Compassionate	Conventional
Assertive	Does not use harsh language	Friendly
Athletic	Eager to soothe hurt feelings	Happy
Competitive	Feminine	Helpful
Defends own beliefs	Flatterable	Inefficient
Dominant	Gentle	Jealous
Forceful	Gullible	Likable
Has leadership abilities	Loves children	Moody
Independent	Loyal	Reliable
Individualistic	Sensitive to the needs of others	Secretive
Makes decisions easily	Shy	Sincere
Masculine	Soft spoken	Solemn
Self-reliant	Sympathetic	Tactful
Self-sufficient	Tender	Theatrical
Strong personality	Understanding	Truthful
Willing to take a stand	Warm	Unpredictable
Willing to take risks	Yielding	Unsystematic

On tests of internal consistency, the results showed the scale to be highly reliable: masculinity = .86, femininity = .80-82, androgyny = .85. Test-retest reliability is also high: masculinity r. = .90, femininity r. = .90, androgyny 7. = .93. No degree of validity has been established.

This scale was selected primarily because it is one of the few scales that measures androgyny. Most other scales reflect a conceputalization of masculinity and femininity as bipolar ends of a single continuum. In other words, a person had to be either masculine or feminine, but not both, which for all purposes negated the concept of androgyny. In addition, this is a well-developed measure with high reliability. It is also relatively short and easy to administer.

(c) Attitudes Towards Sex and Abortion

Although this is identified as one aspect of female sex role, two separate instruments were used, one to assess attitudes towards sex and the other to assess attitudes towards abortion.

In order to assess attitudes towards sex, Miller's "Sexual Attitude Questionnaire" was used. This is a thirty item Likert-type scale. Responses vary from "agree completely" to "disagree completely." This instrument contains two basic scales, a Sexual Regulation Scale and a Sexual Satisfaction Scale. Thus, there are two distinct scores on this scale for each subject.

In his discussion of the development of the instrument, Miller pointed out the two scales

> . . . tap into two fundamental and distinct aspects of human female sexuality. Sexual regulation appears to be a measure of how the woman has been socialized with regard to her sexual behavior, with an essential dimension being the degree of control and inhibition which governs her sexual behavior. Women scoring high on Sexual Regulation should exhibit more sexual control and inhibition than women scoring low. The scale also seems to be a measure of the conditions under which sex is acceptable and potentially pleasurable, with high scorers having a more limited set of conditions than low scorers. . . . The implication is that this scale measures the amount of regulation imposed by a woman, consciously or unconsciously, on her sexual behavior.
>
> . . . In contrast, the sexual satisfaction scale appears to measure a very different dimension, one related to the amount of gratification which occurs with sexual behavior and the emotional importance of that gratification. High scorers on this scale should feel that sex is important, be interested in sex and orgasm as ends in

> themselves, to be relatively relaxed and easily aroused, and have clear and positive feelings about their own sexuality. On the other hand, low scorers should feel that sex is not of great importance, be interested in sex for non-sexual purposes, be relatively indifferent to achieving orgasm, be relatively tense and slow to arousal, and be confused or ambivalent about their own sexuality.
>
> . . . Intercorrelation between the two scales is -.13 (Miller, 1973).

A complete copy of Miller's "Sexual Attitude Questionnaire," as it was presented in the survey packet, is included in the appendix. Several items are here presented, in order to familiarize the reader with the scale and its format.

I think it is a good idea for a woman to experiment sexually before she gets married.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

I would enjoy seeing sexual intercourse in a movie.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Sometimes when I don't feel like making love, I'll agree to it anyway.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

This questionnaire was developed through a series of exploratory studies in which volunteers were interviewed by Miller and his assistant. The third version of the scales, combined into the "Sexual Attitude Questionnaire," was validated on several large populations of married and unmarried women (Miller, 1975).

At this time no further work has been done on validating the scale. Nor is any data available, as yet, regarding test-retest reliability. Nonetheless, this scale is the best such measure the investigator found to assess attitudes towards sexuality. The face validity of the scale is high. Finally, it was selected for use in this study because the two scales, as described by Miller, are designed to measure the two aspects of female sexuality that this study has identified as crucial to women's attitudes towards their own sexuality.

In order to measure attitudes towards abortion, a simple instrument was devised for use in this study, after an extensive search of the literature uncovered no instrument designed to assess attitudes towards abortion. Initially, several different series of questions were

pilot tested in the hope of developing an instrument which would reveal a single scalar variable: positive to negative attitudes towards abortion. The instrument eventually adapted for use in this study does not, in fact, measure a simple scalar variable. As it finally evolved, the instrument is a ten item Likert-type scale, with responses varying from "agree completely" to "disagree completely."

The complete scale, as it was presented to respondents, is included in the appendix. Several items are here presented to familiarize the reader with the scale.

Abortion is not justifiable just because it were likely the fetus is mentally or physically abnormal.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Abortion should be performed ONLY to protect the life of the pregnant woman.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Abortion is justifiable whenever a pregnant woman does not want a child, for whatever personal reasons she may have.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

Although the instrument does not measure a single scalar variable, it has obvious face validity in assessing a general positive to negative attitude towards abortion. The instrument was included in the study because, in spite of its limitations, it provides an important if approximate estimate of a variable that is potentially crucial to the outcomes of this study.

(d) Perceived Work Options

A simple instrument to assess individual's perceptions of the job/career possibilities open to them was developed for use in this study. This instrument, as it finally evolved, consisted of a total of ten questions: five multiple choice questions with responses ranging from "very likely" to "very unlikely" and five fill-in questions. It was pre-tested for readability and clarity with three groups: twenty-eight (28) Junior League women, twenty-four (24) B'nai Brith women, and thirty (30) community college students.

Although at the time it was pre-tested, no difficulty was reported in responding to either

the multiple choice or fill-in questions, when the completed surveys were coded it became apparent that the study population had had some difficulty in dealing with the fill-in questions. Many respondents left the fill-in questions blank; many others responded in ways that were impossible to code. Consequently, only the five multiple choice questions were used in computing scores on this scale.

The complete scale, as it was presented to respondents, is included in the appendix. The five multiple choice items, used to compute the score on this scale, are here presented, to familiarize the reader with the scale.

If you are not now married, how likely is it that you will marry? (If you <u>are</u> married, circle E.)

A	B	C	D	E
Very likely	Moderately likely	Moderately <u>un</u>likely	Very <u>un</u>likely	Now married

How likely is it that you will work full time or part time during the next five years?

A	B	C	D
Very likely	Moderately likely	Moderately <u>un</u>likely	Very <u>un</u>likely

If you worked, do you think you could earn enough money at your work to support yourself and live comfortably on your <u>own</u> salary?

A	B	C	D
Very likely	Moderately likely	Moderately <u>un</u>likely	Very <u>un</u>likely

If you were to work within the next five years, how likely is it that you would get a great deal of personal satisfaction from your work?

A	B	C	D
Very likely	Moderately likely	Moderately <u>un</u>likely	Very <u>un</u>likely

If you were to go to work, how likely would it be that you'd be promoted, or earn some special recognition?

A	B	C	D
Very likely	Moderately likely	Moderately <u>un</u>likely	Very <u>un</u>likely

This series of questions has obvious face validity as a rough measure of a respondent's reported perceptions of future work possibilities, as well as work related success and job satisfaction possibilities. It was developed and used because of the hypothesized importance of this variable and because an extensive search yielded no previously developed instruments designed to measure an individual's perceptions of his/her work options. No tests of reliability or validity were performed on this instrument.

[B] BACKGROUND CHARACTERISTICS

(a) Contraceptive Knowledge Questionnaire

A short questionnaire designed to assess the respondent's degree of knowledge about contraception was included in the survey packet to provide some data for discussing the degree to which "contraceptive ignorance" played a role in the pregnancies of the women included in this study. This questionnaire consisted of fifteen (15) straightforward factual questions about reproduction and the efficacy of various forms of birth control. Answers were presented in a multiple choice format.

A complete copy of this questionnaire, as it was presented to respondents, is included in the appendix. The first three items are here presented, to familiarize the reader with the scale.

A good indication of a woman's ability to become pregnant is:

(A) her overall health
(B) the regularity of her menstrual periods
(C) the amount of her sexual desire
(D) her ability to achieve orgasm

Which of the following is the most reliable method of birth control:

(A) condom (rubber)
(B) the pill
(C) diaphragm plus jelly or cream
(D) rhythm (safe period)

Following its release from the ovary the human egg is capable of being fertilized for:

(A) 6 to 12 hours
(B) 24 hours
(C) 48 hours
(D) 9 to 10 days

This questionnaire is a shortened form of Miller's (1975) "Sexual and Contraceptive Knowledge Questionnaire." The original version consists of a total of twenty-three (23) factual questions to be answered through a multiple choice format. The shortened version contains fifteen (15) of the original twenty-three (23) questions. Eight questions were dropped either because they demanded too technical a degree of knowledge about reproduction and contraception for relevance to the general public and/or because they tested knowledge not necessary to successful family planning, or because they did not relate directly to facts about reproduction or contraception.

(b) Personal Data Sheet

Each subject completed a personal data sheet designed to provide background information

considered potentially relevant to the study. Background data was collected on age, race, marital status, educational level achieved and occupational status. This data is valuable for two reasons: it makes it possible to describe the study sample in detail, and in that it will be possible to hold each variable constant and assess its influence on the research findings.

It is important to note that while this study is concerned with four (4) interrelated aspects of perceived female role-- (1) attitudes towards the rights and roles of women in society, (2) psychological androgyny, (3) attitudes towards sex and abortion, and (4) perceived work options--there are seven (7) dependent variables being analyzed in the study. This is accounted for by two facts: (1) there are three separate variables--sexual satisfaction, sexual regulation, attitude towards abortion--associated with the aspect labeled "attitudes towards sex and abortion"; and (2) scores on the contraceptive knowledge questionnaire were computed along with the scores on all the other scales included in the survey.

6. Data Analysis.

This study is designed to identify whether the four identified groups (effective contraceptors, aborters,

repeat aborters, and problem pregnancy carriers) differ with respect to any, all, or some combination of seven hypothetically important dependent variables.

Step 1

Univariate tests of group differences on each variable cannot be conducted independently. Therefore, this study requires a multivariate test allowing calculation of a probability level for all measures taken jointly for all groups. In this case, a one way multivariate analysis of variance (MANOVA) was used to test the overall null hypothesis of no group difference. A "significant" result would indicate that there is at least one dimension (as defined by some linear combination of dependent variables) on which certain of the groups probably differ.

Step 2

If significant dimension(s) of intergroup difference were discerned, the next step in the analysis will be to determine (a) which groups accounted for the differences, and (b) which dependent variables or groups of dependent variables accounted for the differences.

Step (2a) will be accomplished using Hotelling's T^2, which identifies significant pairwise contrasts between groups. Appropriate alpha levels for these pairwise contrasts between groups will be set so that the joint alpha

(i.e., the probability of finding significance by chance for all pairwise contrasts) does not exceed the alpha level (α_0) employed in the MANOVA. The MANOVA α will be divided by the number of pairwise contrasts to compute the contrast alphas (α_2). Thus, α_2 equals .008. This is an acceptable but conservative procedure (Bock, 1975).

Step (2b), identifying dependent variable(s) accounting for group difference(s) could be accomplished through numerous procedures. The "protected F" analysis was chosen as the most straightforward in cases characterized by relatively few (≤ 10) dependent variables of presumably equal importance in the significant dimensions of intergroup differences. This procedure involves the examination of univariate F tests for each dependent variable at error rate (α) levels of $\frac{\alpha_0}{p}$ where α_0 is the MANOVA error rate level and p equals the number of dependent variables. In this study α_0 equalled .05, and p equalled six. Thus, α_1 equals .007.

Variables on which significant differences between groups are observed are interpreted to be primary contributors to the significant dimensions of intergroup differences. The protected F does not uncover significant intergroup relationships attributable to combinations of variables.

Step 3

The final data analysis procedure involves applying univariate t-tests to (1) the comparisons identified as significant in the first step using Hotelling's T^2, and (2) the variables identified as significant in the second step using the univariate "protected F." These t-tests are interpreted as significant at the α_3 level (α_3 being determined using the same method described for 2a and 2b). Thus, α_3 equals .0004. The univariate t-test reveals which groups probably differ on the particular variable for which significant differences are observed.

This data analysis is summarized in the following flow chart.

Insert Figure 2:1 about here

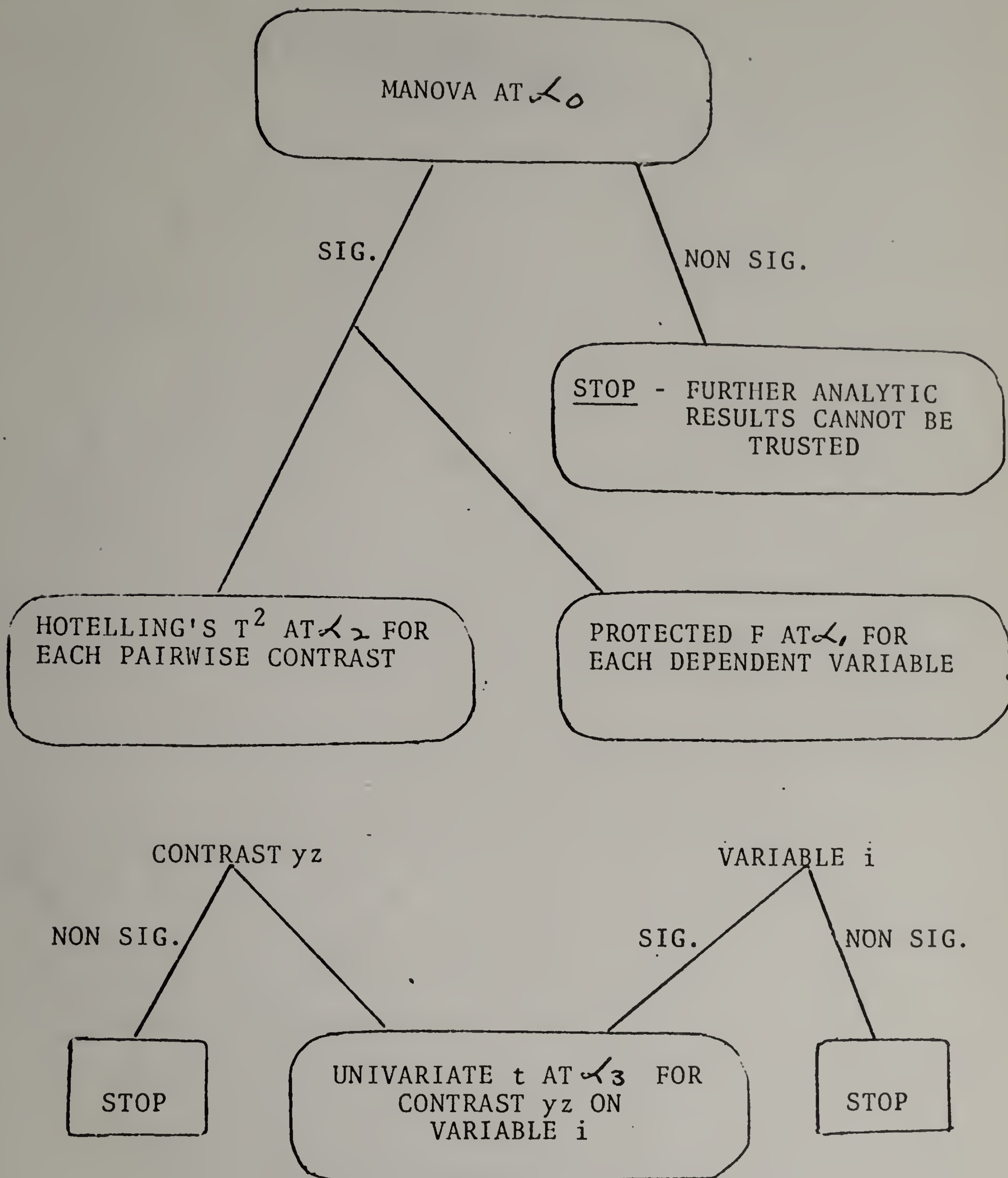
Step 4

Two final tests of statistical analysis will be employed to determine the impact of demographic characteristics of the study population of the results of the study. First, a series of simple Chi-Square tests will be used to determine whether or not demographic differences between the groups are, in fact, statistically significant.

Second, a multivariate analysis of covariance will be used in order to determine whether responses on the dependent

Figure 2:1

DATA ANALYSIS SEQUENCE



This analytic scheme is described in Bock (1975: 420-425).

variables are attributable to criterion group membership, when demographic differences in the groups are held constant.

Summary of Hypotheses

The hypotheses of this study may be expressed in their null form in the following step by step progression:

Hypothesis I:

The four studied groups--effective contraceptors, aborters, multiple aborters, and problem pregnancy carriers--are not significantly different with respect to any combination (i.e., dimension) of the seven dependent variables.

If Hypothesis I is rejected, then the study tests

Hypothesis II:

No group is significantly different from any other group with respect to any combination of the seven dependent variables.

and,

Hypothesis III:

The four groups do not differ significantly on any single dependent variable.

If both Hypotheses II and III are rejected, then the study tests

Hypothesis IV:

There are no significant pairwise differences between any of the four groups on any of the singly significant dependent variables.

In addition, if there are significant differences among the groups on any demographic characteristics, the study tests Hypothesis V:

No identified demographic differences in the populations of the four groups account for the significant differences found in Hypothesis I.

CHAPTER III

FINDINGS

This study tested five sequentially order hypotheses. This chapter will (1) restate the five hypotheses in their null form and report the results of the study in terms of these hypotheses and (2) discuss the significant results as they relate to the primary premise of the study.

Results

Null Hypothesis I:

The four studied groups--effective contraceptors, first abortion clients, repeat abortion clients, and problem pregnancy carrying clients--were not significantly different with respect to seven dependent variables--attitude toward abortion, attitude toward the rights and roles of women in society, androgyny, sexual regulation, sexual satisfaction contraceptive knowledge, and perceived work options--either singly or in any combination.

Insert Table 3:1 about here

Null Hypothesis I was rejected, $p < .05$. The rejection of this hypothesis indicates that there are probably true

TABLE 3:1

MULTIVARIATE ANALYSIS OF VARIANCE TEST FOR THE HYPOTHESIS OF NO GROUP EFFECT

Test	Value	Approximate F (df)	Decision Role
Hotelling-Lawley Trace	1.46	7.58 (21:326)	$p \leq .0001$
Pillai's Trace	0.75	5.29 (21:336)	$p \leq .0001$
Wilk's Criterion	0.36	6.38 (21:316)	$p \leq .0001$

differences in the mean vectors of the four groups on the seven variables. The rejection of Null Hypothesis I permits the test of Null Hypotheses II and III.

Null Hypothesis II:

No studied group was significantly different from any other group with respect to any combination of the seven dependent variables.

Insert Table 3:2 about here

Null Hypothesis II was rejected, $p < .008$, for four of the six possible combinations.

TABLE 3:2

MULTIVARIATE ANALYSIS OF VARIANCE TEST FOR THE HYPOTHESIS OF NO SIGNIFICANT DIFFERENCES (I.E., $p \leq .008$) BETWEEN GROUPS: HOTELLING T^2

Group Contrast	Value	F (df = 7:52)	Decision Role
1 vs. 2	0.43	3.21	sig ($p \leq .0068$)
1 vs. 3	0.19	1.40	not sig ($p \leq .2240$)
1 vs. 4	1.44	10.71	sig ($p \leq .0001$)
2 vs. 3	0.10	0.78	not sig ($p \leq .6109$)
2 vs. 4	1.42	10.53	sig ($p \leq .0001$)
3 vs. 4	1.42	10.53	sig ($p \leq .0001$)

Null Hypothesis III:

The four groups do not differ significantly on any one dependent variable. No dependent variable is significantly different with respect to the four studied groups.

Insert Table 3:3 about here

Null Hypothesis III was rejected, $p < .007$, for five of the seven dependent variables:

1. Attitude toward abortion.
2. Attitude toward the rights and roles of women in society.

TABLE 3:3

MULTIVARIATE ANALYSIS OF VARIANCE TEST FOR THE HYPOTHESIS OF NO SIGNIFICANT DIFFERENCES (I.E., $p < .007$) OF DEPENDENT VARIABLE MEANS WITH RESPECT TO THE STUDIED GROUPS

Variable	η^2 (df=3)	Decision Role
Attitudes toward Abortion	.495	sig ($p \leq .0001$)
Sexual Regulation	.322	sig ($p \leq .0001$)
Attitude toward Rights and Roles of Women in Society	.285	sig ($p \leq .0001$)
Androgyny	.224	sig ($p \leq .0001$)
Sexual Satisfaction	.189	sig ($p \leq .0001$)
Perceived Work Options	.067	not sig ($p \leq .0438$)
Contraceptive Knowledge	.004	not sig ($p \leq .9281$)

3. Androgyny.

4. Sexual regulation.

5. Sexual satisfaction.

Null Hypothesis III was rejected, $p < .007$, for two of the seven dependent variables--contraceptive knowledge and perceived work options.

Null Hypothesis IV:

There are no significant pairwise differences between any of the four groups on any of the singly significant dependent variables.

Insert Table 3:4 about here

Null Hypothesis IV was rejected, $p < .0004$, for twelve of the twenty comparisons permitted as a result of the tests of Hypothesis II and III.

On the sexual regulation scale, the effective contraceptive client group's mean score was significantly different from the first abortion client group's mean score.

On scales measuring attitudes towards women in society, androgyny, sexual regulation and sexual satisfaction, the effective contraceptive client group's mean scores were significantly different from the problem pregnancy carrying group's mean scores.

On scales measuring androgyny and attitudes towards abortion, the first abortion client group's mean scores were significantly different from the problem pregnancy carrying group's mean scores.

On scales measuring attitudes towards women in society, androgyny, sexual regulation and attitudes towards

TABLE 3:4

UNIVARIATE ANALYSIS FOR THE HYPOTHESIS OF NO SIGNIFICANT DIFFERENCES BETWEEN THE MEAN SCORES OF THE FOUR GROUPS ON THE SEVEN DEPENDENT VARIABLES

	F Value for Each Variable Significant F Values ($p < .0004$) Are Underlined						
Group Contrasts	Attitudes Toward Abortion	Sexual Regulation	Satis-faction	Androgyny	Attitudes Toward Women in Society	Perceived Work Options	Contra-ceptive Knowledge
Group 1 vs. 2	0.5	<u>15.29</u>	<u>10.98</u>	.02	6.08	*	*
Group 1 vs. 3	*	*	*	*	*	*	*
Group 1 vs. 4	<u>55.06</u>	<u>43.06</u>	<u>23.91</u>	<u>17.68</u>	<u>34.77</u>	*	*
Group 2 vs. 3	*	*	*	*	*	*	*
Group 2 vs. 4	<u>58.42</u>	12.68	5.65	<u>15.65</u>	13.53	*	*
Group 3 vs. 4	<u>61.14</u>	<u>21.89</u>	6.81	<u>15.91</u>	<u>25.47</u>	*	*

*No univariate analysis of these comparisons was permissible, because the group contrasts were not significant in the multivariate analysis (see Table 3:2) or the variable's means were not significantly different with respect to the groups in the multivariate analysis (see Table 3:3).

abortion, the repeat abortion client group's mean scores were significantly different from the problem pregnancy carrying group's mean scores.

Null Hypothesis IV was not rejected, $p < .0004$ for the remaining eight comparisons.

Null Hypothesis V:

No identified demographic differences in the populations of the four groups account for the significant differences found in Hypothesis I.

There are significant differences among the groups in terms of race, education, and employment.

Insert Tables 3:5, 3:6, 3:7 about here

However, when these demographic differences are covaried out (MANCOVA), the differences between groups on designated outcome variables remain significant. Therefore, Null Hypothesis V was accepted.

Insert Table 3:8 about here

TABLE 3:5

RACE OF GROUP MEMBERS: SIGNIFICANCE OF DIFFERENCES AMONG GROUPS

Group	White		Non-White	
	N	Percent	N	Percent
Contraceptive Clients	23	76.7	7	23.3
Abortion Clients	22	73.3	8	26.7
Repeat Abortion Clients	29	96.7	1	3.3
Carrying Clients	13	43.3	17	56.7
Total	87	72.5	33	27.5

$x^2 = 21.84$, df = 3, $p < .0001$

TABLE 3:6

EMPLOYMENT STATUS OF GROUP MEMBERS: SIGNIFICANCE OF DIFFERENCES AMONG GROUPS

Group	Employed		Unemployed	
	N	Percent	N	Percent
Contraceptive Clients	22	75.9	7	24.1
Abortion Clients	19	65.5	10	34.5
Repeat Abortion Clients	21	70.0	9	30.0
Carrying Clients	12	40.0	18	60.0
Total	74	62.7	44	37.3

$x^2 = 9.54$, df = 3, $p < .05$.

TABLE 3:7

EDUCATIONAL ATTAINMENT OF GROUP MEMBERS: SIGNIFICANCE OF DIFFERENCES AMONG GROUPS

Group	High School Graduates 0 - Less		One or More Years of College	
	N	Percent	N	Percent
Contraceptive Clients	9	30.0	21	70.0
Abortion Clients	15	50.0	15	50.0
Repeat Abortion Clients	13	43.	17	56.7
Carrying Clients	25	83.3	5	16.7
Total	62	51.7	58	48.3

$x^2 = 18.55$, df = 3, $p < .01$.

TABLE 3:8

MULTIVARIATE ANALYSIS OF COVARIANCE FOR THE HYPOTHESIS OF NO GROUP EFFECT WHEN RACE, EDUCATION, AND EMPLOYMENT STATUS OF GROUP MEMBERS ARE CONTROLLED

Test	Value	F (df =)	Decision Role
Hotelling-Lawley Trace	1.02	5.08 (21:314)	sig ($p \leq .0001$)
Pillai's Trace	0.63	4.09 (21:324)	sig ($p \leq .0001$)
Wilk's Criterion	0.45	4.59 (21:304)	sig ($p \leq .0001$)

Discussion

The findings of this study confirm the important relationships between several aspects of female sex role and women's management of their fertility. This section discusses (1) the findings of this study with respect to these relationships and (2) several findings which are important because of the absence of significant relationships discovered.

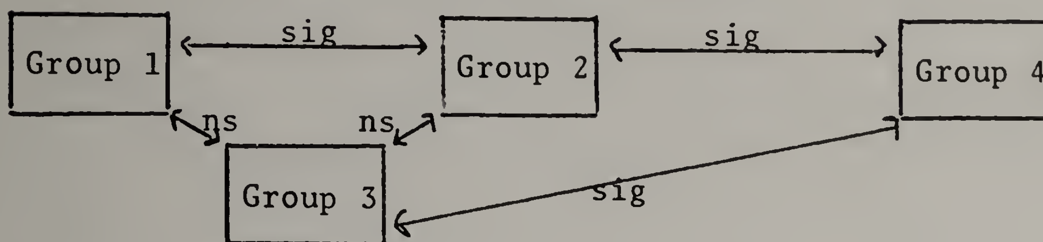
Effective contraceptors were found to be significantly different from abortion clients for only a single variable: effective contraceptors were significantly less sexually regulated (more liberated) than first abortion clients (γ = p .0004). Thus this study's findings primarily reveal

differences between effective contraceptors and abortion clients on one hand, and problem pregnancy carrying clients on the other hand.

The MANOVA resulted in a single dimension of significant intergroup differences with respect to the dependent variables. A graphic approximation of the relationship between the four groups can be depicted as follows:

Figure 3:1

GRAPHIC APPROXIMATION OF RELATIONSHIP BETWEEN THE FOUR GROUPS



This study did not find the predicted differences and orderly progression from Groups 1 through 4 with respect to all variables. However, the predicted direction of differences was found on the variables between Groups 1, 2, 3 and 4: Groups 1, 2, 3 were more profeminist, more androgynous, more sexually satisfied and more liberated (less regulated) than Group 4. As expected, Groups 1, 2, 3 had much more positive attitudes towards abortion than Group 4.

Contrary to the theoretical prediction of this study, no differences among the groups were identified with respect to perceived work options. It is possible that this is more a reflection of inadequancy in the instrument designed to measure this variable than an accurate reflection of reality. The instrument assessing perceived work options might yield the predicted results after further development or reconceptualization.

Finally, the findings of this study provide additional confirmation for the premise that contraceptive knowledge is not an important source of variance in women's fertility management behavior. Virtually no differences were found in the amount of contraceptive knowledge possessed by the different groups.

Aspects of female sex role and fertility management.

This study provides an exploratory test of the premise that the degree to which women have internalized aspects of female sex role accounts for important portions of the variation in women's fertility management behavior. The MANOVA revealed that the four variables comprising "aspects of female sex role" accounted for important percentages of the variance among the four studied groups: attitudes towards the rights and roles of women in society, 28.5 percent; psychological androgyny, 22.4 percent; sexual regulation, 32.2 percent, and sexual satisfaction, 18.9 percent (Table 3:3).

Table 3:9 reports the group means on each variable comprising "aspects of female sex role."

Insert Table 3:9 about here

The mean scores of each group for each variable reported in Table 3:9 make apparent what the MANOVA suggested: Groups 1, 2, and 3 are similar to each other and different from Group 4 with respect to each of the measured aspects of female role, except perceived work options. All of these differences were in the theoretically predicted direction.

A. Attitudes towards the rights and roles of women in society mean scores were significantly more profeminist for Groups 1 and 3 than for Group 4.

This finding is consistent with this study's prediction that more profeminist women are not only better able to avoid an unwanted pregnancy in the first place, but also are more likely to terminate an unwanted pregnancy when it does occur than more traditional women. To the extent that a woman accepts the traditional notion that the proper role for women is "wife-and-mother," it may be more difficult for her to terminate an unwanted pregnancy, and as a consequence negate the possibility of fulfilling her "proper" role.

TABLE 3:9

ASPECTS OF FEMALE SEX ROLE: MEAN SCORES OF EACH GROUP ON EACH VARIABLE

Aspects of Female Sex Role:	Attitudes towards Rights & Roles of Women in Society	Psychological Androgyny	Attitudes towards Sex		Perceived Work Options
Variables (Instruments)	AWS (Spence)	BSRI (Bem)	Sexual Satis- faction (Miller)	Sexual Regu- lation (Miller)	Work Options (Irons)
Meaning of Scores:	0 = traditional 75 = profeminist	0 = androgyny	36 = high 0 = low	54 = high 0 = low	15 = most options 0 = no options
Group:					
1. Effective Contraceptors	58.933	.886	22.400	19.333	11.400
2. Abortion Clients	51.767	.959	18.333	28.200*	10.500
3. Repeat Abortion Clients	56.800	.820	19.167	25.200	11.700
4. Problem Pregnancy Carrying Clients	38.733**	4.404***	14.700*	36.500**	10.067

*Significantly different from Group 1, p .0004.

**Significantly different from Groups 1 and 3, p .0004.

***Significantly different from Groups 1, 2, and 3, p .0004.

B. Psychological androgyny mean scores were significantly lower, i.e., <u>more</u> androgynous, for Groups 1, 2, and 3 than for Group 4.

This finding is consistent with this study's prediction that it is more difficult for women who see themselves as highly feminine to behave in such a way as to abrogate the ultimate feminine role and function. An alternative interpretation of this finding is that to whatever extent the BSRI measures actual personality differences--as opposed to measuring differences in self-image--androgynous women are more able or more willing to act assertively and decisively to either avoid or terminate an unwanted pregnancy than more feminine women, who are more characteristically yielding and passive.

C. The sexual regulation mean scores showed significantly less regulation for Groups 1 and 3 than for Group 4 (Group 1 was also significantly less regulated than Group 2). Sexual satisfaction mean scores for Group 1 were significantly higher than for Group 4. The sexual regulation findings support the notion that the woman who is more accepting of her own sexuality is better able to manage her sexuality/fertility so as not to become pregnant. Evidently, if

such a woman does become pregnant, she is more likely to choose abortion than to choose to bring an unwanted child into the world.

The mean sexual satisfaction scores of Groups 2, 3, 4 were more similar to each other than they were to Group 1. It is interesting to note that this variable, "sexual satisfaction," was the only one differentially distinguishing the comparison of Groups 1 and 4, from the comparison of Groups 3 and 4. In other words, Group 1 was different from Group 4 on five variables, including "sexual satisfaction"; Group 3 was different from Group 4 on four variables, not including "sexual satisfaction." On the basis of these findings, one can speculate that women who are more sexually satisfied and more able to enjoy sex for its own sake may be more able to plan on sexual encounters and to take precautions to avoid an unwanted pregnancy.

D. Perceived work options did not distinguish among the groups. Although this theoretically important variable may, indeed, account for substantial variance in successful fertility management, it is impossible to assert this on the basis of the findings of this study.

In summary, aspects of female sex role account for an important portion of the variance in successful fertility management. However, such aspects do not distinguish between first and repeat abortion clients. Such aspects distinguished effective contraception and abortion clients only with respect to their sexual regulation. Thus, this study did not find a continuum from effective contraceptors to abortion clients to repeat abortion clients to problem pregnancy carrying clients with each progressively less profeminist, less androgynous, less sexually satisfied and more regulated (less liberated) than the last. The continuum must be modified to exclude Group 3. Moreover, it appears that effective contraceptive and abortion clients are somewhat more similar to each other than predicted; they are more profeminist, androgynous, sexually satisfied and less sexually regulated than the problem pregnancy carriers, who are quite different from the other groups in regard to these aspects of female role.

The importance and direction of influence of these aspects of female sex role were confirmed, while the sequential ordering of the four groups with respect to the variables was not confirmed.

Chapter IV will discuss the implications of these findings for assisting in the management of fertility and suggest avenues for further research.

CHAPTER IV

CONCLUSIONS AND IMPLICATIONS

This study set out to extend the present state of our understanding of the ways in which women's fertility management behavior is related to their perceptions of female sex-role and perceptions of norms for role appropriate behaviors. The premise that the study undertook to test is that there _is_ a direct relationship between the degree of profeminist views held by a woman and the degree of success that same woman would have in managing her fertility so as to avoid an unwanted pregnancy.

As noted in Chapter II, in order to explore this relationship, this study compared the attitudes towards female sex-role and perceptions of role appropriate behavior of four groups of women who, at the time of the study, differed in the ways they were managing their fertility. The four groups--(1) effective contraceptors, (2) abortion clients, (3) repeat abortion clients, and (4) problem pregnancy carrying clients--responded to survey measures of four interrelated aspects of female role, as well as a "contraceptive knowledge" questionnaire. The

four aspects of female role measured were (1) attitudes towards the rights and roles of women, (2) psychological androgyny, (3) attitudes towards sex and abortion, and (4) perceived work options.

This study does reveal a significant relationship between aspects of women's sex-role orientations and their fertility management behavior. To the extent that it explicates the phenomena of unwanted pregnancy and childbirth, it should be useful to the family planning professionals who are seeking to understand this complex phenomena and who are attempting to assist women in learning to manage their fertility. Moreover, this study documents new data on the specific costs to women and to society of rigid, stereotypical sex-role socialization. This data should prove useful to the social scientists who are attempting to understand the impact of sex-role socialization on human behavior.

This chapter (1) interprets and summarizes the conclusions that may be drawn from the findings of this study, (2) explores the implications of these findings for family planning researchers and practioners, and (3) concludes with an outline of the social and political ramifications of coercive and oppressive female sex-role definitions in relation to fertility management.

Principal Conclusions

Contraceptive Knowledge

A principal finding, quite consistent with the premise of this study, is that knowledge about contraceptives and how to use them is not a critical determinant of fertility management behavior. This assertion is based on the fact that there were no significant differences in the mean scores of any of the four groups on the contraceptive knowledge questionnaire. In fact, all four groups scored within three tenths of one point of each other [(1) 9.367, (2) 9.100, (3) 9.233, (4) 9.00] on the questionnaire. In effect, then, all four groups possessed a comparable amount of knowledge about contraceptive technology. This finding lends credence to the notion that knowledge about contraception is necessary but not sufficient to insure effective contraceptive practices. Given that most family planning agencies see the provision of information about contraception and the correct use of contraception as the cornerstone of their educational and counseling programs, one hopes the increasingly strong evidence that more is needed will eventually lead to changed practice.

Overall Differences Among Groups

As noted in Chapter III, the existence of a continuum from effective contraceptive clients to abortion clients to

repeat abortion clients to problem prengancy carrying clients with respect to aspects of sex-role orientation was not confirmed. The mean group scores on these variables were ordered as theoretically predicted from effective contraceptors to abortion clients to problem pregnancy carriers, but the differences did not all meet the very conservative standards for significance employed in this study. Thus, the present study can only confirm the predicted distinction between the problem pregnancy carrying group and the other three groups as a whole, although the complete continuum may well be found to hold in further studies.

In effect, the first three groups were a good deal more similar to each other than this study initially predicted. The only significant difference found between contraceptive and abortion clients was that abortion clients were significantly <u>more</u> sexually regulated (less liberated) than contraceptive clients. This may mean that contraceptive clients could be characterized as more accepting of their sexuality and thus more able to acknowledge that they are likely to engage in sexual activity than abortion clients. It would follow then that contraceptive clients are better able to prepare for sexual encounters and protect themselves from an unwanted pregnancy than are abortion clients who see sex as acceptable and pleasurable in more limited circumstances. It may well be that abortion

clients are unwilling to secure contraception in advance of a sexual encounter because this would demand some acknowledgement, to themselves and/or to their partners, that they are likely to engage in sexual activity. To the extent that one denies one's sexuality, one is unlikely to own up to the fact that a sexual encounter is a possibility and contraception may be necessary. Thus, on the basis of these findings, it is possible to conclude that acceptance of one's sexuality is critical to contraceptive effectiveness. This conclusion would be consistent with Klerman's (1975) assertion that the lag between actual sexual practices and society's moralistic attitudes towards sexual practices (to the extent that one has internalized society's moralistic stances and/or fears societal condemnation) makes it difficult for women to obtain and use contraception. Thus, these attitudes may account for a number of unwanted pregnancies.

Another plausible way of looking at these findings would be to conclude that abortion clients are unclear about their values regarding sexual activity and thus are unable to behave in ways that are fully consistent with their own value systems. The findings on the sexual regulation scale indicate that contraceptive clients believe it is acceptable to engage in sexual activity in a

fairly broad range of circumstances. Their behavior is evidently fairly consistent with their value systems, in that they acknowledge to themselves that they are likely to be sexually active and prepare for sexual encounters by obtaining contraception. Abortion clients, in contrast, have somewhat more traditional value systems in that they see sex as acceptable in more limited circumstances. Further, their behavior is not always consistent with those values, in that they may engage in sexual activity in circumstances beyond the perimeters that they themselves have defined as acceptable. It may be that abortion clients do not seek contraception because they have never had the opportunity to examine these contradictions, and articulate (to themselves) their own value systems. Consequently, it may be that abortion clients are unable to predict when they are likely to need contraception. On the other hand, it is also possible that they are unable to adequately articulate their value systems so that in situations in which there is pressure to engage in sexual activity, they are unable to modify their behavior so that it is consistent with their own value systems. Undoubtedly, the mixed messages about sex and sexuality perpetrated by society makes it quite difficult to achieve clarity about one's values regarding sex.

In other words, it is possible to reach two slightly different conclusions on the basis of the findings regarding sexual regulation. It is possible to conclude that in order to be an effective contraceptor, one must be able to accept one's sexuality, acknowledge that a sexual encounter is a possibility and that contraception may be necessary. It is also possible to conclude that in order to be an effective contraceptor, one must possess some clarity about one's own value systems regarding sex and be capable of behaving in ways that are consistent with that value system.

Perhaps the more general hypothesized differences between contraceptive clients, abortion clients, and repeat abortion clients do not exist. It is certainly possible to take the perspective that abortion is simply another method of birth control. There are many other countries and/or other cultures in which it is the primary method of birth control. Historically, abortion has been practiced for centuries, often without any moral injunctions against its use. Thus it is possible to look at the bias against abortion and in favor of pre-conception methods of birth control as simply a matter of personal morality and/or preference. Given that stance, it may be possible to assert that any attempt to convince women that pre-conception methods of birth control are inherently "better"

than post-conception methods of birth control, is simply the imposition of one's own set of principles and preferences on others. In other words, with the exception of the differences related to sexual regulation, abortion clients and repeat abortion clients may be no different from contraceptive clients.

However, the lack of demonstrated differences may have resulted from

1. inaccurate self-reports on the basis of which subjects were assigned to the contraceptive group, or the single or multiple abortion group.
2. the fact that contraceptive failure occurs frequently among couples who are trying diligently to avoid conception (Tietze, 1974); thus it may be that some of those included in Group 2 and Group 3 are actually contraceptive clients who have recently experienced a failure of contraceptive method.
3. the fact that the respondents in all three groups were self-selected clients of one agency in one city; it may be that the data merely documents the fact that all Planned Parenthood of Greater Charlotte clients are more similar than dissimilar in their attitudes towards female sex-role in general.

Additional studies of similar design are needed to determine whether the more general, hypothesized attitudinal differences between contraceptive clients, abortion clients, and repeat abortion clients do, in fact, exist.

Nonetheless, given that no other statistically significant differences were found between Groups 1, 2, and 3, it is necessary to note that the statements that follow pertain to differences between women who manage to avoid an unwanted birth (as opposed to an unwanted pregnancy) and women who proceed with an unwanted pregnancy and carry it to term. The data shows dramatic significant differences in the female sex-role orientation of women who manage to avoid an unwanted birth, whether they use pre-conception or post-conception measures to do so, and women who carry an unwanted pregnancy to term and give birth to an apparently unwanted child. Women who choose to avoid an unwanted birth are significantly more profeminist on all measures except work-options (as noted in Chapter III, the work options instrument failed to measure any differences at all among groups) than the carrying group. In other words, the women who chose to avoid an unwanted birth had significantly more liberal, profeminist views regarding the rights and roles of women in society than the carrying group. They possessed broader perceptions of female role, to a greater extent saw women as deserving options equal to the options available to men in business and the community,

and they valued equity in terms of the rights of women to a greater extent than the carrying group. As a group they were significantly more androgynous than the carrying group. They scored higher on the sexual satisfaction scale--indicating that they feel comfortable about their sexuality and feel sexual gratification is important to them--than the carrying group, which scored low on this scale. They scored lower (more liberated) on the sexual regulation scale than the more traditional carrying group. The scores of the carrying group on the sexual satisfaction and sexual regulation scales indicated ambivalence in terms of accepting their own sexuality, and an interest in sex for non-sexual purposes such as compliance or affection-getting as opposed to sexual gratification per se.

The group that chose to avoid an unwanted birth possessed a much more liberal attitude towards abortion than the carrying group, which was not surprising. The high anti-abortion score may result from the carrying group finding it difficult to separate sex and sexual behavior from its reproductive function. A second possibility is that abortion, an act which terminates the possibility of becoming a mother for the time being, is more offensive and more threatening to the more traditional women who see motherhood as their natural and proper role, and--perhaps--the only meaningful role available to them. On the other hand, it may well be that the surprising strength of "attitude towards abortion" as a variable is a

function of cognitive dissonance: abortion-seeking women may report more positive attitudes about abortion around the time of the abortion than they would otherwise report, whereas women in the throes of a pregnancy, who chose not to abort, may look at abortion as even more repugnant than they otherwise would in order to assure themselves that they made the right decision.

It is to be noted that significant demographic differences among the groups do exist. Nonetheless, the MANCOVA revealed that significant differences among the groups on designated outcome variables remained after controlling for the variance attributable to race, educational attainment and employment status. In other words, it may be said that perceptions of female sex-role and perceptions of norms for role appropriate behavior--rather than race, level of educational attainment, or occupational status, per se--account for significant percentages of the variance in fertility management behavior among the four groups.

At the same time, the obvious numerical differences (see Table 2:1) among the groups on race, level of educational achievement, and occupational status were statistically significant (see Tables 3:5, 3:6, 3:7), and demand comment. Group 4--problem pregnancy carriers--had a substantially higher percentage of black women (56.7 percent) than the

other three groups. Group 4 also had the highest percentage of unemployed women (60 percent). Group 1--contraceptive clients--had the highest percentage of women who had had one or more years of college (70 percent) and Group 4 had the lowest percentage of women with any college experience (16.7 percent).

These findings are not inconsistent with the major premise of this study. It is perfectly plausible that the black women, undereducated women, and underemployed women who make up these statistics are particularly astute in their perceptions of social, economic, and political realities, see that there are few socially and economically rewarding options available to them, and thus choose marriage and motherhood as the only viable alternative available. It may well be the social, economic, and political conditions--institutionalized racism, in particular--which lead to lack of education and underemployment, also lead to a more traditional, less pro-feminist attitudinal stance. The systematic exclusion of young black women from socially and economically rewarding alternatives may, in fact, program them for membership in Group 4. In the face of racial discrimination and oppression, and the subsequent absence of educational and employment opportunities, the bearing of a child may provide existential meaning, proof of worth, meaningful work, and a legitimate role for women who see little else available for themselves.

This study could have employed a stratified random sampling design, to avoid the demographic differences noted. However, the resulting study population would not have been representative of these groups as they actually occur in the general population. Nor would such a procedure have allowed an answer to the question "How do effective contraceptors, abortion clients, repeat abortion clients, and problem-pregnancy carrying clients, _as these groups are actually constituted_, differ with respect to the variables in question?" The relationship of the significant demographic differences to fertility management behavior deserves further study, now that this study has established that the specified significant attitudinal differences do exist, in spite of these demographic differences.

At any rate, it is most telling that, with the exception of work options, the carrying group was more traditional and less profeminist on every measure. This finding is highly consistent with the prediction of this study. There is a relationship between women's perceptions of female sex role and their fertility management behavior. More profeminist women experience greater success in avoiding an unwanted birth than more traditional women. The traditional female sex-role makes it very difficult for women to separate theri sexuality from their reproductivity; it makes it difficult for women to envision viable roles for

themselves other than the traditional role of wife and mother; thus it is not surprising that of the women surveyed in this study it was the women who had most completely internalized this traditional female role who were carrying-to-term pregnancies that they themselves had defined as problem and/or unwanted pregnancies. The implications for family planning practioners seem clear: in order to enable women in managing their fertility and having only as many children as they want to have, it is imperative that women be given opportunities to reassess their perceptions and definitions of female sex role and be assisted in moving beyond the rigid sex-role socialization that demands of them that they deny their sexuality, and learn to value themselves only in the role of wife-and-mother.

Implications

Implications for Future Research.

This study, by definition, is an exploratory study. Although the results seem promising, this particular study is limited in a variety of ways: the study sample is relatively small; the study was performed in a limited geographic location, and the findings may or may not be applicable in other locations; the study sample was comprised mostly of clients of one agency; the study population was relatively homogeneous in terms of religion,

ethnicity, age, and educational status; the study relied strictly on self-report on self-administered survey instruments. This study dealt only with women between the ages of eighteen and thirty, whereas the greatest number of unwanted pregnancies are now occurring among an adolescent population. Teenagers were not included in this study only because this investigator was unable to gain access to an adequately large teenage sample. Thus, this study remains to be replicated in other geographic areas and with other age groups, particularly with teenagers.

This study was not successful in identifying statistically significant differences between women who successfully use contraception to avoid an unwanted pregnancy and women who employ abortion to terminate an unwanted pregnancy. Nonetheless, although the results on the survey measures did not meet the conservative standards for significance employed in this study, they did--in general--fall in the predicted direction and are suggestive enough to demand further pursuit. It is quite possible that differences in perceptions of female sex-role and role appropriate behaviors would be a useful track to pursue in explicating the differences between these two groups, and that this study was simply inadequate to the task of properly measuring the differences between the two groups.

The impact of perceived work options on fertility management behavior demands exploration. This investigator still firmly believes perceived work options to be an important variable that was simply not adequately tested in this study. The conceptualization and development of a research instrument capable of testing this variable is a worthy task, which remains to be accomplished.

Further, this study did not yield any one simple, short diagnostic instrument which could be used by family planning practioners to pinpoint clients at risk of unwanted pregnancy and in need of preventive intervention. The results of this study would seem to indicate that the Sexual Regulation Scale of Miller's Sexual Attitude Questionnaire comes closest to fulfilling this need. The Sexual Satisfaction Scale (Miller) and the AWS (Spence) also seem to hold some promise as diagnostic instruments. The development and refinement of an easily administered diagnostic instrument demands pursuit.

Implications for Practioners.

Implications for the family planning practioners who are attempting to help people better manage their fertility are provocative. Presently the educational and counseling programs of the vast majority of family planning agencies are based on information-sharing about contraceptive

technology. The findings of this study suggest such programs might be more effective if they were designed to enable women to re-examine and redefine their ideas and beliefs about female role, as well as providing information about contraceptives and how to use them.

To the extent that women have narrow perceptions of the rights and roles of women in society, they need to be educated to a broader perception of roles for themselves as women in business, the professions, the community. To the extent that women see themselves as handmaidens to the men in their lives, they need to be educated to the possibility of equity and mutuality in relationships. Moreover, women need to be educated to prepare for and demand socially and economically rewarding alternatives to marriage and motherhood.

To the extent that the effective use of contraception demands of women that they assess their situations, make rational decisions about the costs and benefits of contraceptive use versus possible pregnancy, and act assertively to obtain contraception, effective contraceptive use may be said to demand androgynous behavior, in that the above--the analytical ability necessary to assess the situation, decisiveness, and assertiveness--are so-called masculine traits. Thus, in order to assist women to develop the ability to manage their fertility effectively,

it may well be necessary for family planning agencies to undertake to train women to be more androgynous.

Finally, to the extent that the ability to use contraception effectively is related to one's level of comfort with one's own sexuality, it may well fall to family planning agencies to establish programs to help people accept their own sexuality, achieve greater sexual satisfaction, and explore their own values regarding sexual regulation so that they can consciously prepare for sexual encounters in a way that is consistent with their own value system.

The development of educational and counseling programs to provide these kinds of intervention strategies would demand a considerable commitment on the part of family planning agencies, first to a retraining of their own staffs and then to a thorough and careful development of new programs. Possible models for the above do exist: the consciousness-raising group does provide a potential model for the kind of group in which women can come together to examine their perceptions of female role; assertiveness training provides a model for assisting women in developing more androgynous styles of interaction; value clarification and sexual attitude workshops provide models for the kind of programs that enable people to examine the

relationships between their values and their behaviors; pre-orgasmic groups provide a model for a program designed to enable women to become more comfortable with their sexuality. Initially, these already existing models could be modified and used by family planning practioners, as they explore and develop new programs of their own.

At any rate, given the magnitude of the problem of unwanted pregnancies, the lifelong consequences of ill-timed childbirth for both mother and child, and our relative lack of success in helping people to avoid these problems, radical program changes are called for.

Social and Political Implications.

To the extent that inadequate fertility management behavior is linked to the degree of internalization of traditional female sex role, it may be posited that it will be difficult to encourage better fertility management behavior without attacking coercive and oppressive sex-role norms. The perpetuation of oppressive sex-role norms may be seen as one outcome of institutionalized sexism. In the United States, notions about fertility management--like notions about sex role--are shaped, in large part, by institutions: churches, schools, social organizations, medical institutions, mental health institutions, family planning institutions. These institutions are not value neutral. They tend to perpetuate traditional values and

social norms. It is through these institutions that the female sex role is perpetuated and reinforced. The sum effect of these institutional ideologies, in action, is to support an image of women as objects rather than subjects. Moreover, women are taught to see themselves as individuals who should choose to subordinate themselves in wife/mother roles because these roles are so highly valued by the culture. This study found that women with more androgynous, profeminist, and sexually liberated attitudes managed their fertility more effectively than more traditional women, in the sense that they avoided unwanted births. In effect, then, the problem of unwanted pregnancy can be attributed, at least in part, to our most venerated social institutions. Thus it can be argued that it will not be possible to solve the problem of unwanted pregnancy until our social institutions can be educated to more progressive attitudes towards women and institutionalized sexism can be eradicated. Such an argument depends on correlational rather than causal findings, but cannot be lightly dismissed.

The point has been made that women's--particularly black women's--perceptions of themselves as having few options other than marriage and motherhood, is neither neurotic nor an indicator of psychological problems. It is an accurate perception of reality and a reflection of the status of women in society. Perhaps it is no accident that

Group 4, the group carrying problem pregnancies to term, had the highest proportion of black women, undereducated women, and underemployed women. The fewer options available to a woman, the more likely she is to risk an unwanted pregnancy and if she does become pregnant, to carry it to term. For those with limited options, marriage and/or motherhood may well be the most viable alternative. It would seem obvious, then, that one part of the solution to the problem of unwanted pregnancy is to create more and better educational and employment opportunities for women, especially for black women.

The principal social and political implication of this study should be to contribute to a redefinition of the problem of fertility management. As long as the problem is defined as in individual women who fail to effectively manage their fertility, then women will continue to be assumed to be either stupid or unable to control themselves. However, if women's fertility management behavior is governed--as it seems to be--by perceptions of female sex-role and role appropriate behavior, then those wishing to influence fertility management behavior need to focus on examination and redefinition of that role.

The present study's findings provide an additional bit of evidence that the greater the degree of pro-feminist attitudes a woman achieves, the less likely she may be to

carry an unwanted pregnancy. Thus the problem is not in women. The problem is in our social norms and in our definition of female sex role, in the mass media presentation of women as sex objects and sex as a commercial commodity, in the social institutions which continue to support women only in their roles as wives and mothers, and in the institutionalized sexism and racism which continues to deprive women of equity of employment and educational opportunity. From this system-blaming as opposed to woman-blaming perspective, the problem of fertility management is one front of an overall struggle to overturn practices and beliefs that oppress women.

Finally, it is noteworthy that all research on contraception has been directed toward methods to be used by women. There has been no major thrust towards development of birth control methods to be used by men. This is obviously problematic in that it demands of women that they accept total responsibility for birth planning. Moreover, the research that has been done has been severely limited by lack of funding, and researchers have as yet failed to develop a foolproof method of birth control that does not have serious deleterious side effects. In other words, the woman who conscientiously uses the most effective methods of birth control subjects herself to relatively serious medical risks. This is an unacceptable situation, and one

that is not likely to change until social policy-makers and those in control of funding sources commit themselves to the further development of safe and effective contraception. Women's health, well being, and comfort must be taken into consideration. Further, a commitment to development of contraceptives to be used by men is of obvious necessity if men and women are ever to share responsibility for what is by nature a mutual act.

Summary

In summary, then, this study has found a significant relationship between aspects of women's sex role orientations and their fertility management behavior. Thus it provides empirical support for the psycho-social explanation for unwanted pregnancies, which argue that internalization of social-sexual role is linked to fertility management. This is particularly important because, to date, intervention in the problem of unwanted pregnancy has been based almost entirely on two other prevailing theories: "Contraceptive Ignorance" and "Intrapsychic Conflict." This study suggests some alternative interventions might be more useful. In particular, this study suggests a two-pronged attack on the problem: (1) through educational and counseling approaches provide opportunities for women to examine and redefine their perceptions of female sex-role and (2) through

broad based social changes begin to attack the institution-alized sexism which contributes to the problem. The social and personal costs, to women and to society at large, of huge numbers of unwanted pregnancies is such that the problem demands immediate attention.

APPENDIX

RESEARCH QUESTIONNAIRE
ON
CLIENT ATTITUDES AND NEEDS

PLANNED PARENTHOOD OF GREATER CHARLOTTE
East Independence Plaza • 951 S. Independence Blvd.
Charlotte, North Carolina 28202

On the following pages, you will find a number of different questionnaires. Please note that there are several different ones, and that each has its own set of directions. Please follow the directions carefully.

Planned Parenthood is requesting that you carefully fill out each questionnaire. Our reason for requesting this is that we are now in the process of doing some research about how our clients feel about a variety of different topics. We need to do this research in order to improve our services and be sure that our services fit the attitudes and needs of our clients.

Please note that you are not being asked for your name or address on any of the research sheets. Your answers to the questions we have asked will be completely anonymous. So, you can feel free to be absolutely honest in the way you answer all the questions. It is very important to us that we get your help in improving our services. We cannot do a better job without your help on this research.

Honest: this is not as long as it looks. It will take you approximately 15-30 minutes to fill out.

There are three sections. In the first section we ask you some questions about yourself. The second section has to do with your knowledge about birth control. The third section has to do with your attitudes on a variety of topics.

If you have any questions, or want any follow-up information, please feel free to contact Edith Irons, here at Planned Parenthood (377-0841)

Thank you.

SECTION I

No. ________

PERSONAL DATA

AGE ____________ RACE ________________ RELIGION ________________

MARITAL STATUS (Circle One)

Single Married Separated Divorced Widowed

EDUCATIONAL LEVEL (Please Circle Highest Grade Completed)

Elementary								High School				College				Post Graduate	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	17+

IF YOU PLAN ON CONTINUING YOUR EDUCATION, PLEASE CIRCLE THE STATEMENT THAT COMES CLOSEST TO DESCRIBING YOUR LONG-TERM GOAL:

Finish High School   Finish College   Learn a Trade

Do Graduate Work   Get Professional Training

Learn Office/Secretarial Skills

YOUR CURRENT EDUCATIONAL STATUS: (Circle One) Student Non-Student

WHO IS FAMILY BREADWINNER: (Circle One)

Self   Husband   Grandparents   Self & Husband Combined

Mother   Father   Other   Mother & Father Combined

IF YOU ARE CURRENTLY WORKING, PLEASE STATE TITLE OF JOB.

____

PLEASE CHECK HIGHEST LEVEL OF EDUCATION ACHIEVED BY EACH OF YOUR PARENTS:

Mother	Father
Grade School	Grade School
High School	High School
College	College
Secretarial/Technical/ Vocational School	Secretarial/Technical/ Vocational School
Graduate School	Graduate School

PLEASE STATE THE TITLE OF THE JOB HELD BY YOUR MOTHER AND FATHER

Mother ____________________ Father ____________________

If either parent is self-employed, please write "self-employed" right below the title of the job.

PLEASE INDICATE THE SECTION OF THE COUNTRY IN WHICH YOU WERE RAISED. (Circle One)

North   South   East   West

SELF-DESCRIPTION

Directions: Below you will find a list of 60 words that can be used to describe a person. We would like you to describe YOURSELF, using these words. Please go down the list, and next to each word, indicate -- on a scale of 1 (never or almost never true) to 7 (always or almost always true) -- how true of you each word is. Please do not leave any word unmarked.

1	2	3	4	5	6	7
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE	OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE

Word	
Self-reliant	
Yielding	
Helpful	
Defends own beliefs	
Cheerful	
Moody	
Independent	
Shy	
Conscientious	
Athletic	
Affectionate	
Theatrical	
Assertive	
Flatterable	
Happy	
Strong personality	
Loyal	
Unpredictable	
Forceful	
Feminine	

Word	
Reliable	
Analytical	
Sympathetic	
Jealous	
Has leadership abilities	
Sensitive to the needs of others	
Truthful	
Willing to take risk	
Understanding	
Secretive	
Makes decisions easily	
Compassionate	
Sincere	
Self-sufficient	
Eager to soothe hurt feelings	
Conceited	
Dominant	
Soft-spoken	
Likable	
Masculine	

Word	
Warm	
Solemn	
Willing to take a stand	
Tender	
Friendly	
Aggressive	
Gullible	
Inefficient	
Act as a leader	
Childlike	
Adaptable	
Individualistic	
Does not use harsh language	
Unsystematic	
Competitive	
Loves children	
Tactful	
Ambitious	
Gentle	
Conventional	

PERCEIVED WORK OPTIONS

Please respond "yes" or "no" to the following questions:

1. Do you have a job now? ____________

2. Do you have a marketable skill? _________

3. If you were put in a position, where you absolutely HAD to support yourself, how would you do it? In the two columns below, please list the jobs you would be qualified to hold (a) Now, (b) Five Years From Now.

(a) Now	(b) 5 Years From Now
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

On the following questions, please circle the response - A, B, C, D - which comes closest to expressing your answers to the questions below.

4. If you are not now married, how likely is it that you will marry? (If you are married, circle E.)

A	B	C	D	E
Very likely	Moderately likely	Moderately unlikely	Very unlikely	Now Married

5. How likely is it that you will work full time or part time during the next five years?

A	B	C	D
Very likely	Moderately likely	Moderately unlikely	Very unlikely

6. If you worked, do you think you could earn enough money at your work to support yourself and live comfortably on your own salary?

A	B	C	D
Very likely	Moderately likely	Moderately unlikely	Very unlikely

7. If you were to work within the next five years, how likely is it that you would get a great deal of personal satisfaction from your work?

A	B	C	D
Very likely	Moderately likely	Moderately unlikely	Very unlikely

8. If you were to go to work, how likely would it be that you'd be promoted, or earn some special recognition?

A	B	C	D
Very likely	Moderately likely	Moderately unlikely	Very unlikely

9. Think back, if you can, to when you were very little (under 10). Do you remember what you wanted to do or be when you grew up? If so, please write down what it was:

____

____

10. Now, think back to when you finished your schooling. As a young woman, what did you want to do with your life? Please write a line or two:

____

____

YOU HAVE JUST FINISHED

SECTION I.

THANK YOU

PLEASE GO RIGHT ON TO SECTION II.

SECTION II

CONTRACEPTIVE KNOWLEDGE QUESTIONNAIRE

Directions: The following is a quiz about birth control and family planning issues. We need to know how much you (our clients) already know, and how much we need to teach. Please circle the letter - A, B, C, D - which indicates the correct response.

1. A good indication of a woman's ability to become pregnant is:
   (A) her overall health
   (B) the regularity of her menstrual periods
   (C) the amount of her sexual desire
   (D) her ability to achieve orgasm

2. Which of the following is the most reliable method of birth control:
   (A) condom (rubber)
   (B) the pill
   (C) diaphragm plus jelly or cream
   (D) rhythm (safe period)

3. Following its release from the ovary the human egg is capable of being fertilized for:
   (A) 6 to 12 hours
   (B) 24 hours
   (C) 48 hours
   (D) 9 to 10 days

4. A man's sperm is released:
   (A) only at the time of ejaculation and orgasm
   (B) only after orgasm is completed
   (C) when he's aroused
   (D) in small amounts before and after orgasm, as well as at the time of ejaculation

5. The normal female generally ovulates (gives off an egg):
   (A) just prior to menstruation
   (B) immediately following menstruation
   (C) 2 weeks before the onset of menstruation
   (D) 1 week after the end of menstruation

6. If a woman has had unprotected intercourse several times without getting pregnant:
   (A) she is probably not fertile at this time in her life
   (B) she is probably less fertile than most women
   (C) her fertility is probably normal
   (D) none of the above

7. Which of the following is the least reliable method of birth control:
   (A) rhythm (safe period)
   (B) condom (rubber)
   (C) douching (washing out the vagina after intercourse)
   (D) intrauterine device (IUD: coil or loop)

8. Menopause is a time of:
   - (A) diminished sexual desire
   - (B) altered menstruation
   - (C) rapid aging
   - (D) absolute infertility

9. In the woman's body, some sperm retain their ability to fertilize for as long as:
   - (A) one-half hour
   - (B) two hours
   - (C) 12 to 18 hours
   - (D) 24 to 48 hours

10. The morning after pill is:
    - (A) available through many physicians
    - (B) being used experimentally with animals only
    - (C) being discussed but as yet only a medical hope
    - (D) a physiological impossibility

11. Which of the following is the least reliable method of birth control:
    - (A) diaphragm plus jelly or cream
    - (B) rhythm (safe period)
    - (C) foam
    - (D) condom (rubber)

12. The time during the menstrual cycle when the chances of pregnancy are lowest is:
    - (A) two weeks after menstruation
    - (B) one week after menstruation
    - (C) two weeks before menstruation
    - (D) just before menstruation

13. It has been shown that the chances of pregnancy can be decreased somewhat by:
    - (A) assuming certain positions during intercourse
    - (B) the woman's not having orgasm
    - (C) a strong desire not to conceive
    - (D) none of the above

14. An abortion performed by a doctor is:
    - (A) never performed after the first 3 months of pregnancy
    - (B) rarely performed before the third month of pregnancy
    - (C) most easily performed during the first 3 months of pregnancy
    - (D) most common performed after the third month of pregnancy

15. Which of the following is the most reliable method of birth control:
    - (A) condom (rubber)
    - (B) foam
    - (C) diaphragm plus jelly or cream
    - (D) intrauterine device (loop or coil)

YOU HAVE JUST FINISHED

SECTION II.

THANK YOU.

PLEASE GO RIGHT ON TO SECTION III.

SECTION III

ATTITUDES TOWARD WOMEN

Directions: The statements listed below represent different attitudes towards the role of women in society. There are no right or wrong answers, only opinions. You are asked to express your feelings about each statement by indicating whether you (A) agree strongly, (B) agree mildly, (C) disagree mildly, or (D) disagree strongly with the statement. Please indicate your response by circling A, B, C, D, right on this sheet.

1. Swearing and bad language are worse in the speech of a woman than a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

2. Women should take increasing responsibility for leadership in solving the intellectual and social problems of the day.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

3. Both husband and wife should be allowed the same grounds for divorce.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

4. Telling dirty jokes should be mostly a masculine privilege.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

5. It's worse for a woman to get drunk than it is for a man to get drunk.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

6. If a woman is working outside the home, the man should share in household tasks such as washing dishes and doing the lanudry.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

7. It is insulting to women to have the "obey" clause remain in the marriage vows, since men don't have to make the same vow.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

8. There should be a strict merit system in job appointment without regard to sex.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

9. A woman should be as free as a man to propose marriage.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

10. Women should worry less about their rights and more about becoming good wives and mothers.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

11. If a woman earns as much as her date does, she should pay half the expenses when they go out together.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

12. Women should assume an equal place in business and all the professions along with men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

13. A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

14. Sons in a family should be given more encouragement to go to college than daughters.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

15. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

16. In general, the father should have greater authority than the mother in the bringing up of children.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

17. Women should not have sex before marriage, not even with their fiances.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

18. Legally, the husband and wife should have equal rights to all family income and property; everything should belong to both of them equally.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

19. Women should be concerned with their duties of childbearing and housetending, rather than with desires for professional and business careers.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

20. The intellectual leadership of a community should be largely in the hand of men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

21. Economic and social freedom is worth far more to women than acceptance of the ideal of femininity which has been set up by men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

22. On the average, women should be regarded as <u>less</u> capable of contributing to economic production than are men.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

23. There are many jobs in which men should be given preference over women in being hired or promoted.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

24. Women should have the same chance to learn a trade as men do.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

25. The modern girl is entitled to the same freedom from rules and control that is given to the modern boy.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

ATTITUDES TOWARD ABORTION

Directions: The following statements are concerned with attitudes toward first trimester (up to 12 weeks) abortion. You are asked to express your feelings about each statement by indicating whether you (A) agree strongly, (B) agree mildly, (C) disagree mildly, or (D) disagree strongly. Please indicate your response by circle A, B, C, or D right on this sheet.

1. Abortion is never justifiable to prevent an illegitimate birth.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

2. Abortion should be performed ONLY to protect the life of the pregnant woman.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

3. Abortion is justifiable whenever a pregnant woman does not want a child, for whatever personal reasons she may have.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

4. It is more moral to have an abortion than to bring an unwanted child into the world.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

5. There is no justifiable reason for abortion; abortion should not be performed under any circumstances.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

6. The decision whether or not to have an abortion, should be completely up to the pregnant woman (or the couple).

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

7. Abortion is not justifiable just because it were likely the fetus is mentally or physically abnormal.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

8. Abortion is justifiable for a married couple if they feel unable to provide financially for a child (or for another child), whether or not they already have children.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

9. Abortion is justifiable to protect the physical, emotional, mental health of the pregnant woman.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

10. Abortion is justifiable for an unmarried woman if she feels she won't be able to provide financially for a child, or make a good home for a child.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

SEXUAL ATTITUDE QUESTIONNAIRE

Directions: The following statements are concerned with sexual attitudes and experience. We would like you to answer each item as it relates to you and your sexual experience. Again, please indicate whether you agree or disagree with the statement by circling A, B, C, or D right on this page.

1. People need sex in their lives in order to be content.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

2. I think it is a good idea for a woman to experiment sexually before she gets married.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

3. I would enjoy seeing sexual intercourse in a movie.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

4. Sometimes when I don't feel like making love, I'll agree to it anyway.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

5. It is all right for a woman to have sexual intercourse with someone she loves but is not married to.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

6. Sometimes it is hard for me to understand how I feel about sex.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

7. I could never have sex with a man just for the physical pleasure.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

8. I prefer to make love at night with all the lights off.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

9. I find I can enjoy masturbation.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

10. I am almost always ready for a little sex.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

11. Much of the time it is unrealistic for a woman to expect her sexual partner to satisfy her.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

12. It is easy for me to become uncomfortable when talking about sex.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

13. It is all right for a woman to have sexual intercourse with someone she knows fairly casually.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

14. There have been times in my life when sex was just no good for me.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

15. Oral sex can be quite enjoyable.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

16. Sometimes I can't seem to relax during sex.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

17. Sexual intercourse before marriage is not as easy for a woman as it is for a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

18. Sex can be a real help in overcoming a couple's problems.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

19. I would be very embarrassed if anyone saw me having sexual intercourse.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

20. Pleasure and physical satisfaction are not the most important part of a sexual relationship for me.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

21. Sometimes sex is dirty and vulgar.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

22. I find it easy to have an orgasm.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

23. It is all right for a woman to have sexual intercourse with someone she knows well and likes but does not love.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

24. I usually enjoy sex more if I've had a drink or two.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

25. Sex is the duty of a good wife.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

26. I have no objection to homosexuality in women.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

27. It is as important for me to have orgasm as it is for a man.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

28. Women often get into trouble sexually because they have had a drink or two.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

29. It takes me a long time to get sexually aroused.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

30. If there was enough time, I would like to have sex several times a day.

A	B	C	D
Agree strongly	Agree mildly	Disagree mildly	Disagree strongly

YOU'VE NOW COMPLETED THE ENTIRE QUESTIONNAIRE

IF YOU HAVE ANY QUESTIONS ABOUT THIS RESEARCH, PLEASE FEEL FREE TO DISCUSS IT WITH YOUR COUNSELOR.

THANK YOU FOR YOUR PARTICIPATION IN THIS RESEARCH.

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