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Bereavement in the Elective Abortion Patient

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BEREAVEMENT IN THE ELECTIVE ABORTION PATIENT

BY

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BEREAVEMENT IN THE ELECTIVE ABORTION PATIENT

This thesis is approved as a creditable and independent investigation by a candidate for the Master of Science degree and is acceptable for meeting the thesis requirements for this degree. Acceptance of this thesis does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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Abstract

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Currently in the United States, approximately 1.5 million elective abortions are performed annually. Despite the frequency in which abortions occur, little research has been done to document women's experiences of voluntary perinatal loss. The purpose of this study was to examine the bereavement process as it occurred in rural women who elected voluntary termination of a pregnancy.

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CHAPTER 1: INTRODUCTION

In 1973, the United States Supreme Court ruled that elective abortions (also referred to as therapeutic, medical, induced, or voluntary terminations) must be offered in all states as long as the pregnancy was under 12 weeks gestation (Reeder & Martin., 1987). It was left up to individual states to determine whether abortions after 12 weeks would be performed and to develop regulations/restrictions concerning those procedures.

Elective abortions are performed for a variety of reasons. Health, economics, circumstances of conception, age, marital status, family stability, and numerous other social and psychological factors affect the decision of the woman to terminate the pregnancy (Reeder & Martin, 1987).

An estimated 1.5 million elective abortions are performed annually in the United States each year, involving 27 out of every 1,000 women between the ages of 25 and 44. Each year nearly three out of every 100 women have an abortion. Forty-three percent have had at least one previous abortion and 49% have had a previous birth (Alan Guttmacher Institute, 1994). The majority of terminations are done prior to 12 weeks gestation.

Perinatal loss and grief have only been recognized as a special form of loss within the last twenty years (Moscarello, 1989). Women who elect to terminate their pregnancy suffer compound loss. First is the personal and physical loss and the second is the social loss (Angelini & Gibbs, 1988).

Historically, the clinical literature on grief and loss has often been concerned with pathological variants, such as depression rather than on the normal bereavement process. Research efforts have addressed grief resulting from pregnancy loss only since the 1970's with most studies focusing on the involuntary forms: stillbirth and neonatal death (Bansen & Stevens, 1992).

Despite the frequency of elective abortion, research on voluntary perinatal loss is limited in number. Few studies have confirmed that losses with elective abortion result in grief reactions (Lloyd et al., 1985; Peppers, 1985; Sellers et al., 1993, Zeanah et al., 1993).

Lloyd (1985) examined the reactions to the termination of pregnancy for fetal malformations. He found 77% experienced an acute grief reaction. Zeanah, et al. (1993) concluded women who terminate pregnancies for fetal anomalies experience grief as intense as those who experience perinatal loss. Sellers, et al. (1993) found that fetal loss through miscarriage or termination of pregnancy for genetic reasons provoked the grief of bereavement. Peppers found grief associated with elective abortion was symptomatically similar to grief experienced following involuntary fetal/infant loss.

Women choose to have abortions for a variety of reasons, regardless of age, race, religion, economic and marital status. Abortion entails loss, but in our society, abortion is a socially negated loss (Joy, 1985). The assumption commonly made is that the woman who has aborted has nothing to grieve. Not having the usual outlets for grief resolutions may promote pathological grief reactions (Joy, 1985; Rando, 1996).

Purpose of the Study

Despite the frequency with which elective abortion occurs, little research has been performed to document the grieving process. Based on the lack of research documenting the grief process in women who undergo elective abortions, the purpose of this study was to describe the bereavement process as it occurred in rural women who elected voluntary termination of the pregnancy.

Definition of Terms

The following terms are utilized in this study:

Abortion: Termination of pregnancy before the fetus is viable (Miller & Keane,

1972).

Elective abortion: Abortion induced legally by a qualified physician for medical or other reasons (Miller & Keane, 1972).

Bereavement: State of having suffered a loss (Rando, 1993).

Grief: Process of experiencing the psychological, behavioral, social and physical reactions to the perceptions of loss (Rando, 1993).

Mourning: Cultural and/or public display of grief through one's behavior (Rando, 1993).

Physical loss: Loss of something tangible (Rando, 1993).

Psychological loss: Loss of something intangible, a "symbolic loss" (Rando, 1993).

Resolution: Accepting reality of the loss both cognitively and emotionally and recognizing the many facets of one's life to accommodate loss (Cook et al., 1992).

Secondary loss: Physical or psychological loss that coincides or develops as a consequence of the initial loss (Rando, 1992).

Significance to Nursing

Perinatal bereavement has become a topic of national concern to all health care providers. Nurses are in strategic positions to have a major impact on the grieving process. Although the literature covers many aspects of grieving, little mention is given to bereavement and voluntary termination.

The subject of abortion remains controversial. Present cultural and societal norms do not include practices that allow others to assist women in grief resolution in these circumstances. Therefore, it is critical to identify bereavement in the abortion population and to meet the distinct needs of women experiencing this bereavement. Health care professionals can then facilitate a women's grief and mourning to a positive outcome of

reconciliation (Rando, 1993; Wolfelt, 1987).

CHAPTER 2: LITERATURE REVIEW

Health care professionals began to recognize the effects of perinatal loss during the 1970's. Most studies focused on stillbirth and neonatal loss, although perinatal loss is sometimes defined to include elective or therapeutic abortion, spontaneous abortion, stillbirth and neonatal death (Moscarello, 1988).

Attachment

The conceptual framework of attachment theory (Bowlby, 1969; 1980) proposed the relevance of attachment to mourning. Development of emotional bonds occurs from childhood to adult life as a normal part of growth and development. If at any time those bonds are threatened, such as with death, certain grief reactions specific to humans can incur. Bowlby (1980) believed that grieving and attachment are intimately connected concepts and postulated that there can be no grief without first having a bond.

Klaus and Kennell (1976) attempted to document prenatal emotional attachment by examining mourning responses of women whose infants had died within the first three months of life. Observable grief in all respondents led them to conclude significant bonding (physically, emotionally and spiritually) had been established by the time of or soon after the birth of the child. They reasoned that length and intensity of mourning is proportionate to the closeness of the relationship prior to death (Klaus & Kennell, 1976).

Peppers and Knapp (1980) gathered data providing direct evidence of early prenatal attachment. Peppers and Knapp (1980) used questionnaires and interviews to study several hundred women who had experienced fetal or infant death. They compared the grief responses of women after miscarriage, stillbirth, and neonatal death. They concluded that the intensity of grief is as great in miscarriage as it is with the loss of a neonate.

Due to the technological advances including early sonography and the advent of

sensitive pregnancy tests, bonding can occur at an early gestational age. Ultrasound imaging provides a visual image of the fetus and perhaps a picture for the family album. Black (1989) interviewed women who experienced voluntary termination following detection of fetal abnormalities. She found variability in women's responses to pregnancy losses, with women who lost pregnancies later in gestation showing the greatest mood disturbances. Lloyd and Lawrence (1985) examined reactions to the termination of pregnancy for fetal malformation. Of the women interviewed, 77% experienced an acute grief reaction after the pregnancy was ended. Kowalski (1987) surmised that attachment occur long before the birth of a baby.

Loss

The concept of loss is complex. Pregnancy losses contain a number of compounding losses including the real and fantasized loss of a baby, pregnancy and birth experience, loss of self esteem, loss of special attention given to pregnant women, relationship losses, loss of parenting experience, and the loss of the opportunity to move to the next stage in the family life cycle (Conway & Valentine, 1988; Kesselman, 1990; Kowalski, 1987; Nichols, 1993; Rando, 1993; Rajan, 1994; Reeder and Martin, 1987; Seller et al., 1993; Wheeler, 1992).

Peretz (1970) defined loss as a state of being without something one once had. He identified types of loss over which people grieve. He grouped types of losses into four categories: loss of a significant loved or valued person, loss of a part of the self, loss of external objects, and loss of stages of normal growth and development. All four types of loss described by Peretz are associated with perinatal death.

In addition to delineating types of loss, Peretz (1970) stressed that loss is simultaneously a real event and a perceptual or symbolic event. Perceptual or symbolic events can produce intense reactions. According to Hall (1987), loss occurring before

quickening (16-18 weeks of gestation) involves loss of a part of self and may be more difficult to grieve than loss of a "definable, external object" (In Zaccardi, p. 803).

Grief and Grieving

Grief reactions involve alterations in feeling states, coping strategies, relationships, self-esteem, biopsychosocial functioning, and world view that may last indefinitely. Manifestations of grief reflect the survivor's personality, previous life experiences, past psychological history, significance of the loss and the nature of the relationship to the deceased. Existing social network, health, and other resources will affect the grief work of the individual (Kaplan & Sadock, 1995).

Despite individual variations in the bereavement process, theorists have proposed grieving process models, which include at least three overlapping phases or states:

1. initial awareness, characterized by shock, disbelief and denial
2. period of acute discomfort and social withdrawal, characterized by sadness and anger
3. resolution or adaption to the loss, characterized by acceptance (Bowlby, 1980; Kubler-Ross, 1969; Rando, 1993; Shaw, 1994; Solari-Twadell et al., 1995; Weeler, 1992; Wolfelt, 1987).

Historically, it has been generally accepted that grief was all alike. According to Freud's (1917) classic paper *Mourning and Melancholia*, the main task of grief involved the withdrawal of emotional ties to the deceased. The mourner gradually detached from the loved one and completed the process of grieving.

Erich Lindemann (1944), in the first empirically based study of grief, described six components of grief: (a) intense somatic distress, occurring in waves and lasting 20 minutes to an hour, manifested by a tight throat, choking and sighing, weakness, tenseness, and mental pain; (b) thoughts of the deceased preoccupying the survivor; (c)

filled with guilt; (d) irritation and anger directed at themselves, the deceased, friends, relatives, doctors, world, or God; (e) restlessness, agitation, aimlessness and lack of motivation accompanied by abandonment of survivor's usual habit patterns; and (f) identification phenomena, adoption of traits, behaviors, or symptoms of the deceased appear and reach pathological proportions. Lindemann was the first grief theorist to offer a time duration for the mourning process. He reasoned that the griever should be able to resolve uncomplicated mourning in 4 - 6 weeks.

Following Lindemann, Kubler-Ross (1969) studied the emotional grief responses of terminally ill adults anticipating their death. She brought the topic of dying to public awareness. Four hundred interviews with dying patients revealed that patients know without being told they are dying, that they need to talk about it, and that they need to maintain hope. Kubler-Ross postulated five stages that dying patients confronted from the time of their prognosis to their actual death: (a) denial, 'no, not me', (b) anger, 'why me?', (c) bargaining, 'Yes me, but', (d) depression, "Yes, me", and (e) acceptance, 'Yes me and I'm ready'.

Worden (1982, 1992) has provided the framework used most recently in grief. In the Worden framework, bereavement is identified as a process involving a variety of emotions. A series of tasks in achievement of grief resolution is described: (a) to accept reality of loss, (b) experience pain and grief, (c) adjust to an environment in which the deceased no longer exists, and (d) withdrawal of emotional energy from the relationship with the deceased and reinvestment in new relationships (Cook et al., p. 16). Cook's model suggested that the healing process is a developmental sequence of cycling and recycling through the four tasks.

As with Kubler-Ross's stages of dying, Worden's grieving tasks do not prescribe a correct course of grief. They are guidelines that describe an overlapping and fluid

process that is individually based. Grief is highly dependent upon the individual's unique perception of loss.

Grief is a natural human response to any loss, whether the loss is real, perceived, threatened or anticipated (Kenner et al., 1993). Grieving is highly influenced by a number of historical and situational factors. Numerous factors mediate grieving: age, type of loss and type of attachment, number of losses, existing relationships, whether the person grieving perceives him or herself as a victim or initiator of the loss, and whether or not the loss is recognized (Conway & Valentine, 1988). In order for an individual to grieve, it is not necessary for the loss to be socially recognized or validated by others (Rando, 1993).

Several studies have addressed specific aspects of the bereavement process. As reported in the literature, the period of mourning varies greatly because grief is so personalized and is influenced by so many factors. Some people can recover from grief in six to eight weeks (Lindemann, 1944). Other researchers (Bowlby, 1980) discovered that grief does not end in the six to eight weeks as hypothesized by Lindemann. Bowlby (1980) estimated that it is probably closer to one year before grief is worked through.

Peppers and Knapp (1980) acknowledged that total resolution of grief surrounding perinatal loss may never occur. They hypothesized that this was due to the mother having no desire to let go of the loss and the inability of the mother to express her grief. They described the phenomena of 'shadow grief' found with maternal reactions to newborn death. They called shadow grief a form of continuing grief in which normal activity may be moderately inhibited, but grieving is not debilitating and requires no effort to cope (Horacek, 1995). Zisook (1982) found that individuals vary in specific symptoms displayed and in the intensity and duration of those symptoms. Conway (1988) found in her qualitative study that the quality of grieving did change over time but

the impact of reproductive loss never completely disappeared. Black (1989) interviewed patients who experienced voluntary termination of pregnancy and found improvements did occur in mood levels within the first 6 months after the loss. Moscarello (1989) found grief following perinatal loss may take six months to two years to integrate or resolve.

Because grieving is highly influenced by a number of historical and situational factors, there are numerous individual differences in the expression of grief. Although labeled and organized differently, theorists agree that symptoms of grief involve four types of expressions: feelings, physical sensations, cognitions, and behavioral disturbances.

Acute grieving is characterized by a specific set of symptoms (Horacek, 1995). Feelings of acute grief may include sorrow, anguish, disbelief, despair, anxiety, loneliness, guilt, regret, resentment, emptiness, and numbness (Tatelbaum, 1980). Physical symptoms include shortness of breath, fatigue, and tightness in the chest and/or throat. Cognitive reactions may include disbelief, confusion, obsessive preoccupation, forgetfulness, recent memory losses, inability to concentrate, and indecisiveness. Behavioral disturbances include sleep and/or appetite disturbances, social withdrawal, nightmares, hyperactivity, and crying (Horacek, 1995; Rando, 1993).

Working through the acute grieving stages/tasks may take months, years and in some instances continue throughout the person's life. Most mourners will experience a return to everyday functioning. This does not mean that they will return to the level of functioning prior to the death, but will function at a new and altered level of well being (Horacek, 1995; Rando, 1993).

Elective Abortion Research

Three categories of research on elective abortion have been identified in the

literature. The categories are: (a)general surveys and epidemiological studies, (b)surveys of political stances toward abortion, and (c)measurements of the psychological effects of abortion.

General surveys and epidemiological studies have provided information on the sociodemographic profiles of women seeking abortion (Alan Guttmacher Institute, 1990; Henshaw & Kost 1996; Tortes & Forrest, 1988). National data describing abortions in the United States cover only basic demographic characteristics, including the procedure used and the length of pregnancy. Shortcomings with these studies include unavailability of a complete sociodemographic profile and not representing current trends (Peppers, 1987).

Some states have no abortion reporting system and underestimation of the number of abortions performed periodically occurs. Henshaw (1996) compiled results of a national survey done in 1994-1995. The characteristics of the abortion population and their use of contraception were examined. This research revealed that women who live with a partner outside of marriage or have no religious identification are 3.5 - 4.0 times more likely than women in the general population to have an abortion.

In checking the representativeness of the Henshaw survey, the results were compared to the 1991 Center for Disease Control compilation of state reports. Of all the characteristics on which comparisons were possible, discrepancies were noted only in the results of Hispanic ethnicity. Reasons for the discrepancies were attributed to sampling facilities having a larger proportion of Hispanic patients in Henshaw's survey. Two other factors noted by the CDC compilation were: (a)characteristics are not known for abortion patients in California, which has a higher abortion rate and high proportion of Hispanics and (b)Hispanic proportion may well have been higher in 1994-1995 than it was in 1991.

Because of the moral/ethical overtones, studies in the second category describing pros and cons of rape and abortion and incest and abortion must be read with skepticism. There are proponents of abortion who present studies regarding the benefits of abortion over the delivery of unwanted children (Zolese, 1992; Visrarn, 1972; Watters, 1980). There are also opponents of abortion who present their studies to refute the findings of the former (Ney, 1979 in Zolese, 1992).

In the third category of research on abortion, several studies have examined the psychological consequences of elective abortion (Brown et al., 1993; Dagg, 1991; Lamb, 1988; Rogers et al., 1989; Rosenfeld, 1992; Zolese & Blacker, 1992). Studies done prior to 1973 encountered problems related to inadequate sampling size and biased by the author's personal attitudes toward abortion. Since 1973, studies attempted to delineate specific emotions arising from the voluntary abortion population. Emotions vary from study to study. Brown (1992) analyzed descriptive letters from women who had negative experiences that they perceived were linked with a past abortion. Emotions expressed included anger, loss, depression, regret, shame, suicidal ideation, and guilt. Studies analyzed by Dagg (1992) found that women were more likely to be depressed before the abortion than after and that 78% expressed feelings of relief, while 33% reported some feelings of guilt with 80% of the guilt being reported as mild.

In the review of the literature, Dagg (1992) found that immediately after the abortion, symptoms of distress and dysphoria occur in many women. However, those symptoms seemed to be present before the abortion and may be a result of the circumstances leading to the abortion rather than the result of the abortion itself. Long term studies show that the majority of women express positive reactions to the abortion and only a minority express any degree of regret. An extensive review of literature requested by the former Surgeon General Koop (1989) revealed insufficient evidence to

support the notion that abortion was psychologically detrimental to women (Wells, 1992)..

Grief in the Elective Abortion

Because of the emotional elements in therapeutic abortion, there may be a tendency to discount feelings of loss and grief associated with selective and elective abortions. Regardless of the type of abortion, feelings of sadness and regret may be experienced with reminders of the baby that never arrived such as the due date, seeing a baby of the same age, and delivery of a healthy baby. Parents, especially the mother, are subject to grief and mourning with abortion, whether it is spontaneous or therapeutic (Zaccardi et al., 1993; Zeanah et al., 1993).

It has been reported that the termination of a pregnancy is almost always felt as a loss (Stotland, 1992). The emotional outcome is best when a woman makes an informed decision. Once the decision is made, it is important that the woman receive all the necessary social and psychological support for her decision. Kesselman (1990) identified the need for women who have had abortions to express unresolved feelings of loss and to deal with issues of death, loss and separation. "Mourning must be allowed to be completed before the experience of abortion, like that of any death, can be assimilated in a healthy way" (p. 247).

Adler (1990) found that women who undergo elective abortion experienced three kinds of emotional reactions: positive emotional; negative socially based; and negative internally based. Positive emotional reactions reflect a sense of relief and happiness. Negative emotions fall into two distinct categories; those that are socially based - shame, guilt and fear of disapproval and those that are internally based - regret, anxiety, depression, doubt and anger.

Joy (1985) looked at factors that contributed to postabortal grief. Two relevant

factors were noted: (a) ambivalent feelings about the abortion and (b) social isolation. In our society, abortion is a socially negated loss. It is assumed that the woman who has aborted has nothing to grieve. Joy (1985) proposed grief counseling for the assistance of resolution of grief for the woman, involving the woman's asking for and being granted forgiveness, releasing her forgiveness, and releasing her from perceived guilt.

Peppers (1987) investigated grief subsequent to elective abortion. He concluded:

1. There is a grief reaction to elective abortion.

2. The grief reaction is most likely initiated when the decision to terminate the pregnancy is made.

3. Some women experience a minimally dysfunctional grief reaction while others suffer greatly.

4. Intensity of grief is associated with the length of the pregnancy.

5. Grief associated with elective abortion is symptomatically similar to that experience following involuntary fetal/infant loss.

Tetoni (1995) counseled five women who had undergone elective terminations. All were experiencing grief and guilt over the termination. All were extremely religious and had not told their parents about the procedure. Findings indicated that in order to help the woman validate the loss, the revisiting of the site of her abortion and holding a Gestalt dialogue with the fetus, ended the relationship.

Teicher, in an unpublished study (1992), looked at the emotional sequelae of viewing products of conception following an induced abortion. It is felt that some women have more difficulty in resolving a loss when there is no baby to identify. His study examined the hypothesis that viewing the products of conception would assist in the resolution of grief following an induced abortion. The findings supported the hypothesis that those who viewed the products of conception have less of a grief response

than those who did not. Teicher used the short form of the Perinatal Grief Scale (Toedter et al., 1988) in his research.

Literature on the social, emotional, and psychological sequelae of voluntary termination, while growing, is relatively sparse. There have been no studies documenting grief associated with elective abortions in a rural population. The present study attempted to document grief among abortion patients in rural Wyoming.

CHAPTER 3: CONCEPTUAL FRAMEWORK

Observations have confirmed that the loss of a fetus can cause intense grief reactions (Nichols, 1993; Peppers, 1987; Rosenfeld, 1991; Seller et al., 1993; Swanson-Kaufmart, 1988; Walkins, 1986; Welch, 1991; Zaccardi et al., 1993) . The psychodynamics of the reactions to the demise have been studied with a number of theories that attempt to explain grief.

Recent theorists emphasize that the work of grief involves attachment. Attachment theory posits a human instinct to form persistent affectionate bonds and that a natural response to the loss of an attachment bond is separation anxiety or grief. Separation anxiety generates an intense, predictable behavior geared to recoup or revive the lost relationship. The first response, protest, is followed by a period of searching behavior. Searching behavior gives way to despair and detachment before the bereaved person eventually recognizes that the deceased person will not return. Thus, grief is viewed as a series of attachment behaviors.

Based on a belief that the intense feeling of grief arises from the underlying phenomenon of attachment, maternal-infant bonding theory (Klaus and Kennell, 1976) provides a framework from which the psychoemotional reaction to voluntary termination of a pregnancy can be systemically examined. From the first four stages of maternal infant bonding theory, it could be inferred that women who elect to terminate their pregnancy will not experience a grief reaction. Election to terminate a pregnancy indicates a lack of acceptance of the pregnancy. For those who cannot accept their pregnancy, the bonding process ceases and abortion becomes an alternative to attachment. According to maternal-infant bonding theory, grieving and bonding are irrevocably connected; there can be no grief without first having a bond (Kowaiski, 1987).

The process of attachment has been studied since the early 1900s. It was not until the 1960s when Rubin (1967) described basic behaviors indicative of the significance of maternal behavior to nursing did the information have an impact on nursing practice.

In the 1970s and early 1980s, the process of parent-infant attachment was studied in depth by researchers. Spitz (1965) demonstrated that infants reared in homes where they were deprived of warm, loving relationships failed to thrive, were more susceptible to infections, and had delayed social and intellectual development. Bowlby (1967) advanced the development of the attachment theory by validating the importance of attachment to the emotional well-being of the child Bowlby believed that attachment was necessary for survival. Ainsworth identified four stages of attachment infant behavior critical to each stage. The distressing effects of separation of the infant from the caretaker were provided as evidence of attachment. Barnett (1970) looked at the development of attachment in the opposite direction, from parent to infant.

Klaus and Kennell (1970) attempted to document prenatal emotional attachment by studying the mourning responses of 20 mothers whose infants had died from one hour to twelve weeks after birth. They reasoned that the length and intensity of mourning was proportionate to the closeness of the relationship prior to death. Following this reasoning, it was anticipated that the strength of the mother's attachment to her unborn baby could be measured indirectly by determining the length and intensity of her mourning after the baby's death. If there had been no attachment, there would be no grief.

In each of the twenty mothers whose infants had died, mourning was clearly identified. Mothers grieved whether the infant lived one hour or many days and whether the pregnancy was planned or unplanned. The presence of mourning implied that bonding had been established long before the birth of the child. Longer and more intense

mourning was noted when the pregnancy was a positive experience for the mother and when she had physical contact with the infant.

The nature and extent of the prenatal attachment is not clearly understood. Many factors are believed to influence the timing progress and process of attachment. Factors associated with attachment include parents emotional health, an adequate social support system, a competent level of communication, and the ability to give care (Klaus & Kennell, 1982). Some women exhibit behavioral and verbal clues suggesting a close attachment while other women remain less obviously engaged to the fetus.

Klaus and Kennell (1976) identified nine stages that are thought to be important to the formation of the maternal-infant bond. These stages are thought to correspond to the months of pregnancy. The attachment process has been described as linear, beginning during the early pregnancy period and being constant and consistent once established.

The process, described by Klaus and Kennell, by which attactment occurs includes: (a) planning the pregnancy, (b) confirming the pregnancy, (c) accepting the pregnancy, (d) fetal movement, (e) accepting the fetus as an individual, (f) birth, (g) seeing the baby, (h) touching the baby, and (i) caretaking. The degree of bonding increases with each event, (See Figure 1).

Prior to the pregnancy, past experiences of the mother are the major determinant to molding her caregiving role. The way the woman was raised, the effects of her culture, and the individual child-rearing practices of her mother all influence the behavior toward the pregnancy and the infant (Klaus & Kennell, 1976).

During the pregnancy, two types of developmental changes occur in the pregnant woman: (a) hysical and emotional changes within herself and (b) growth of the fetus in her uterus. The way in which the woman feels and deals with the changes vary widely

according to whether the pregnancy was planned, her health, economic status, marital status, family stability, circumstances of conception, personal goals, age and many other social and psychological factors.

During the first stage, a woman must come to terms with the pregnancy. A number of considerations all influence acceptance of the pregnancy. If accepted, women become attached to their fetuses, long before fetal movement (Bansen, 1992). According to this theory, women who elect termination, presumably have no grief as no attachment has been made. This theory is based on the assumption that election to terminate a pregnancy indicates a lack of acceptance of the pregnancy (Peppers, 1980).

The second stage involves a growing awareness of the baby as a separate individual. Quickening affirms pregnancy and supports the realization that the baby is firmly within the mother's self image and at the same time a separate entity. During the third trimester, there is a psychological preparation for the physical and psychological separation of the baby from the mother through labor and delivery (Moscarello, 1989).

Based on maternal-infant bonding theory, particularly the first four stages, the following hypotheses can be derived: Hypothesis #1: Women who elect to terminate their pregnancy will not experience a grief reaction. If a statistically significant number of study participants generate scores on the Perinatal Grief Scale indicating that they did not experience grief, the null hypothesis will be accepted. Hypothesis #2: There will not be any significant difference in the mean grief score at the time of the abortion and the mean grief score three weeks post abortion.

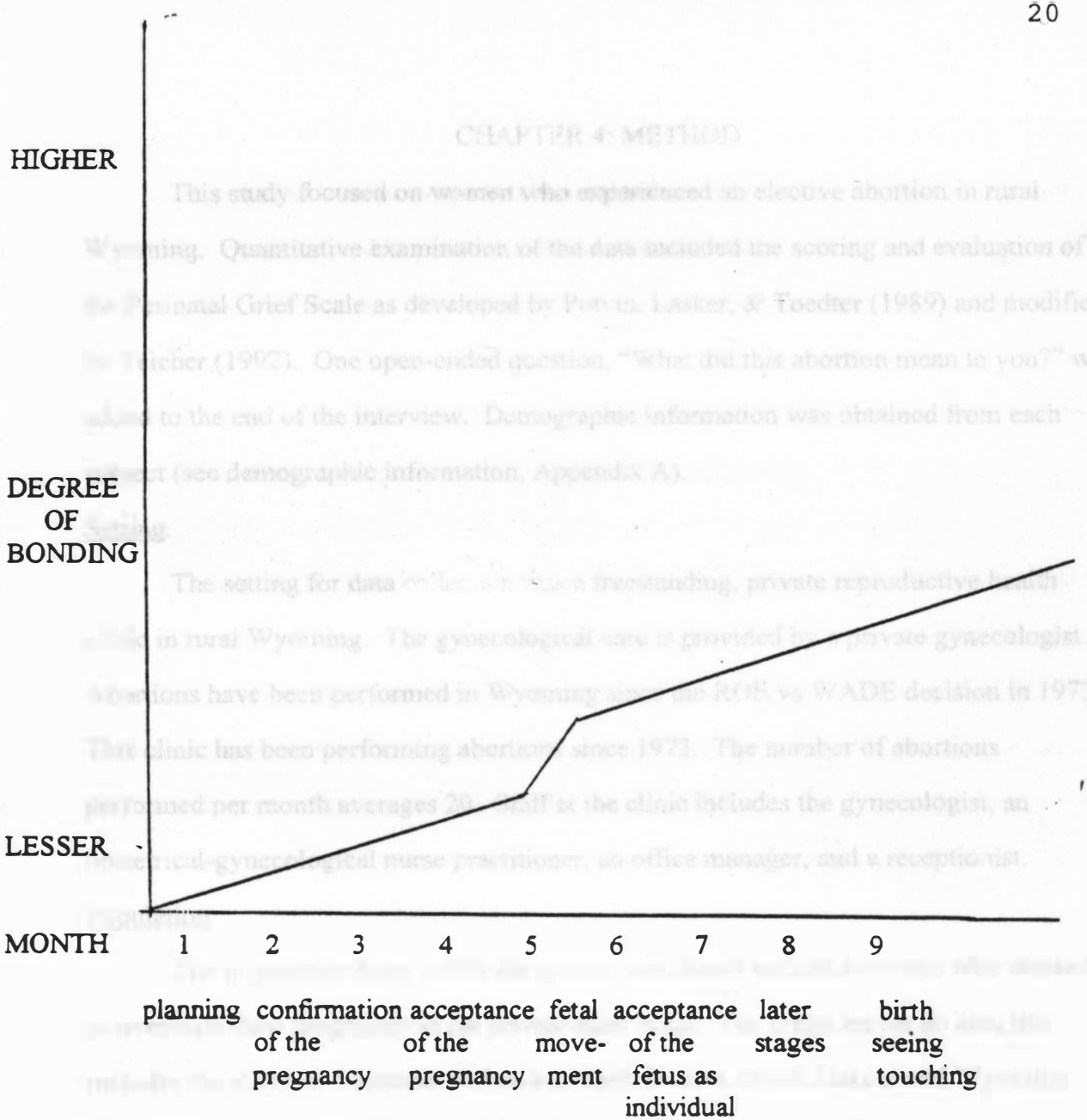


Figure 1: Process of Maternal -Infant Bonding

CHAPTER 4: METHOD

This study focused on women who experienced an elective abortion in rural Wyoming. Quantitative examination of the data included the scoring and evaluation of the Perinatal Grief Scale as developed by Potvin, Lasker, & Toedter (1989) and modified by Teicher (1992). One open-ended question, "What did this abortion mean to you?" was added to the end of the interview. Demographic information was obtained from each subject (see demographic information, Appendix A).

Setting

The setting for data collection was a freestanding, private reproductive health clinic in rural Wyoming. The gynecological care is provided by a private gynecologist. Abortions have been performed in Wyoming since the ROE vs WADE decision in 1973. This clinic has been performing abortions since 1973. The number of abortions performed per month averages 20. Staff at the clinic includes the gynecologist, an obstetrical-gynecological nurse practitioner, an office manager, and a receptionist.

Population

The population from which the sample was drawn included women who elected to terminate their pregnancy at the private rural clinic. The clinic serves an area that includes the states of Montana, Nebraska, North Dakota, South Dakota and Wyoming. The clinic serves all women, regardless of race with the majority of women being of the European-American ethnic heritage. The age category of women ranged from 18 through 44. Marital status included those never married, married, separated, widowed and divorced. Population included ranchers, oil field workers, blue-collar workers and white collar workers, students, and housewives in a rural setting. The nearest abortion clinics are in Boulder, Colorado (285 miles south) and Billings, Montana (270 miles north).

Sample

All pregnant women with an estimated gestational age of 12 weeks or less and who presented for an elective abortion at the named facility over a period of three months were eligible to participate in the study. Women under the age of 18 were excluded (n=12).

Informed consent was obtained (see consent form, Appendix B). Subjects were identified by case number and not by name. All results were anonymous.

Research Tool

The Perinatal Grief Scale was developed by Potvin, et al. (1989) incorporating items from the Expanded Texas Grief Inventory (Zisook, 1982). The initial paper was published in 1988 and included reliablity and validity data (Toedter, 1988). In 1989, a shortened version of the Perinatal Grief Scale was published with the analysis and the discussion of reliability and validity (Potvin et al., 1989).

The Perinatal Grief Scale was constructed to incorporate items that reflected dimensions of grief. Eighty-four items from the long version were grouped into substantive scales reflective of those dimensions. Ten theoretical subscales resulted including: despair, depression, preoccupation, fear, guilt, lack of resolution, disbelief, anger, loneliness and sadness.

An empirical model was developed by factor analysis, which identified three main factors. The model included three subscales, consisting of 11 items in each subscale. Each subscale represented a qualitatively different aspect of grieving. The factor structure differentiated items that represented "normal" grief and those which represented more severe and long lasting effects of loss. There is progression in the severity of subscales from active grief to despair. The first subscale, active grief, reflected feeling sad, missing the baby, crying for the baby, and open expression of grief. Difficulty

coping identified difficulty in dealing with everyday activities and other people. This subscale may indicate more severe depression. The third subscale, Despair, reflected feelings of worthlessness, guilt and vulnerability and suggests the potential for serious and long-lasting effects from the loss.

The scale consists of 33 Likert-type items whose answers vary from strongly agree (1) to strongly disagree (5) (See Appendix C). The original reliability of the total scale and of each subscale were assessed by means of item analysis and Cronbach's alpha. The total scale shows the highest values for Cronbach's alpha (0.95). Three factor-analyzed scales with 11 items in each scale are derived, with internal consistencies of 0.92 (Active Grief), 0.91 (Difficulty Coping) and 0.86 (Despair). It has been validated externally by moderate to high correlations with the Symptom Checklist - 90 depression subscale, the Beck Depression Inventory and a perinatal version of the Grief Experience Inventory.

Slight modifications were made by Teischer (1992) in the scale to apply to induced abortion (See Appendix D). One question (27a) was added that dealt only with induced abortion, but was not included in the total score. An open-ended question was added to the end of the questionnaire, "What did the abortion mean to you?" (See Appendix E).

Data Collection

During the routine pre-procedure counseling session, the study was explained, questions answered and subjects recruited. The only subjects excluded from the study were those under the age of 18. Informed consent was obtained (see Appendix B). All subjects completed a history intake form, including medical, obstetrical, gynecological, psychiatric, family, and social history. Demographic information was completed at the time of the pre-procedure counseling session. The subject was instructed to return the

following day.

On the day of the procedure, all elective abortion patients were medicated with Valium 10 mg and Toradol 20 mg. All abortions were performed using the standard dilatation and evacuation procedure by one physician. The grief scale was administered prior to premedication. Approximately three weeks after the abortion procedure, each participant completed the Perinatal Grief Scale at their routine post-operative examination. Those not returning for their appointments were contacted by phone and the scale was administered over the phone.

Data Analysis

This descriptive study proposed to explore the response of abortion patients to grief immediately following the abortion and 3 weeks postabortion. The null hypothesis was women who elect to terminate their pregnancy will not experience a grief reaction. It was further hypothesized that there would not be any significant difference in the mean score of the Perinatal Grief Scale at the time of the abortion and the mean score on the same instrument three weeks post abortion. The rationale for this hypothesis is based upon the assumption that election to terminate a pregnancy indicated a lack of acceptance of the pregnancy (Peppers et al., 1980)

Data was analyzed using descriptive and inferential statistics. T-tests analysis was calculated using StatMost for Windows. The t-test uses the standard deviation of the sample to estimate the standard error of the sampling distribution. T-tests are used to test for statistical differences between the means of two samples. Using t-tests involves the following assumptions: 1) sample means from the population are normally distributed, 2) the dependent variable is measured at the interval level, 3) there is equal variance in the samples, and 4) there is independence of all observations within each sample (Burns & Grove, 1993). The level of significance accepted for all data analysis was 0.05 for the

current research. The analysis is presented in Chapter 5.

In addition to this hypothesis, several variables are considered to be significant to the abortion decision and aftermath. Given the moral, legal and social controversy surrounding the issue of abortion, variables such as religion, age, income and social support might have an impact on a woman's feelings regarding the decision to terminate the pregnancy. Such variables may impinge upon her reaction to the abortion. For the purposes of this study, demographic variables were not used for relationship studies, but were used only to describe samples.

Approval

Approvals were obtained from:

1. Dr. Cheatham, Gynecologist and owner of the clinic.
2. The Human Subjects Committee of South Dakota State University. (See Appendix F).

CHAPTER 5: RESULTS

Descriptive Variables of Sample

A consecutive series of 50 women were treated by the gynecologist in a private freestanding clinic during the study period. Thirty-eight women consented to participate in the study. Thirty completed the requirement of the study.

For the purposes of this study demographic variables were not used for relationship studies but were used to describe samples. The variables considered were age, ethnic heritage, marital status, religion, education, enrolled in school, currently employed, family income, Medicaid coverage, region of residence, county of residence, GYN history, weeks of gestation and contraceptive method used at the time of conception.

Characteristics of the 30 women in the sample are shown in Table 1.

Table 1
(OB/GYN Demographic Variables are shown in Table 2)

Characteristics of Samples According to Demographic Variables (n=30)

AGE DISTRIBUTION	**ETHNICITY**
30% 18-22 (9)	0% African-American (0)
27% 23-27 (8)	0% Asian-American (0)
13% 28-32 (4)	77% European-American (23)
13% 33-37 (4)	3% Hispanic-American (1)
17% >38 (5)	20% Native American (6)

MARITAL STATUS	**RELIGION**
17% Married (5)	27% Protestant (8)
10% Separated (3)	13% Catholic (4)
33% Divorced (10)	0% Jewish (0)
3% Widowed (1)	37% Other (11)
37% Never Married (11)	23% None (7)

EDUCATION

0% <8TH GRADE (0)
7% 9th-11th grade (2)
27% HS graduate or GED (8)
53% Some college (16)
13% College graduate (4)

ENROLLED IN SCHOOL

23% Yes (7)
77% No (23)

CURRENTLY EMPLOYED

87% Yes (26)
13% No (4)

FAMILY INCOME

43% <$15000 (13)
37% $15000-29999 (11)
7% $30000-59999 (2)
10% >$60000 (3)
3% unknown (1)

HAS MEDICAID COVERAGE

7% Yes (2)
93% No (28)

REGION OF RESIDENCE

0% Montana (0)
0% Nebraska (0)
0% North Dakota (0)
3% South Dakota (1)
97% Wyoming (29)

COUNTY OF RESIDENCE

3% Converse (WY) (1)
3% Pennington (SD) (1)
84% Natrona (WY) (25)
7% Campbell (WY) (2)
3% Fremont (WY) (1)

TABLE 2
OB/GYN Demographic Variables

OB/GYN HISTORY (N=31)

13% 1st pregnancy (4)
58% Prior term birth (18)
6% Prior miscarriage (2)
23% Prior elective abortion (7)

NO. OF LIVE BIRTHS (N=23)

30% 1 (7)
44% 2 (10)
26% 3 (6)

WEEKS OF GESTATION (N=30)

20% Less than 7 (6)
70% 8 - 10 (21)
10% 11 - 13 (3)

CONTRACEPTIVE METHOD USED AT TIME OF CONCEPTION (N=30)

0% Sterilization (0)
0% Implant (0)
0% IUD (0)
0% Injectable (0)
23% Pill (7)
27% Condom (8)
0% Female Condom (0)
3.5% Diaphragm (1)
0% Sponge (0)
13% Foam (4)
0% Suppository (0)
3.5% Periodic Abstinence (1)
3.5% Withdrawal (1)
3.5% Other (1)
23% None (7)

Sample characteristics

The sample consisted of 30 women. Fifty-seven percent were under the age of 27 with the majority not being married (83%). The sample was mostly European-American (77%), working (87%), educated (66%) women.

Eighty-seven percent of the women had a job outside of the home. Forty-three percent had incomes less than $15000. Ninety-three percent were not on Medicaid coverage. Most of the women identified a religious preference (77%). Ninety-seven of the sample resided in Wyoming with 84% residing in Natrona County.

The average gestation at the time of the abortion was 10 weeks or less (90%). Twenty-three percent had a prior elective abortion. Twenty-three percent listed no contraception at the time of conception.

Inferential Variables of the sample

Hypothesis #1: Women who elect to terminate their pregnancy will not experience a grief reaction.

Potvin et al. (1988) determined the scoring of the Perinatal Grief Scale to range from a low score of 33 to a high score of 165. To agree with the item (with exception of those reversed) indicated a lower score and a higher level of grief.

The Perinatal Grief Score at the time of the abortion for the group of 30 women were totaled and the mean score and standard deviation from the mean were obtained. As shown in Table 3, statistical analysis of the preabortion score revealed a mean of 130.50, with ranges of scores from 57 to 162. This showed a moderate dispersion of scores around the mean indicating the women were varied in their responses at the time of the abortion.

Hypothesis #2: There will not be any significant difference in the mean Perinatal Grief Score at the time of the abortion and the mean Perinatal Grief Score three weeks post abortion.

The Perinatal Grief Scores, pre and post-abortion, for the group of 30 women were totaled and the mean score and standard deviation from the mean were obtained. A paired t-test was conducted on the pre and post abortion scores. The probability value, as shown in Table 3, was 4.66 which indicates there is no statistically significant difference in the sets of scores at the 0.05 level. Therefore, the null hypothesis was accepted.

Table 3:
Comparison of Prescores and Postscore Range, Mean and Standard Deviation Scores; t-Values, Probability and Standard Deviation of Paired Pre and Post Abortion Scores

	Preabortion		Postabortion	
Sample Size	30		30	
Number of Missing	0		0	
Minimum	57.0		76.0	
Maximum	162.0		165.0	
Standard Deviation	25.1406		21.4417	
Standard Error	4.5900		3.9147	
Coeff of Variation	19.2649		14.9246	
Mean	130.5000		143.6667	
Variance	632.0517		459.7471	
Paired:	t-Value	Probability	Degree of Freedom	Critical t-value
	-4.5305	4.66627E	29	1.6991
CoVariance =	419.2069			
Std Deviation =	2.9062			

For the 0.05 level of probability, the t-value would have to exceed the critical t-value for all of the subscales. Since the t-value of the scores did not exceed the critical value calculated by this measure, the research data suggests that there is no significant difference in the mean score at the time of the abortion and the mean grief score three weeks post abortion. The Perinatal Grief Scale (shortened version) is composed of three subscales: (1) Active Grief, (2) Difficulty Coping, (3) Despair. Each subscale was compared pre-abortion and post-abortion using the paired t-test.

The prescores and postscores of the 3 subscales and their t-values are represented in the following tables (Tables 4 - 6).

Table 4:
Comparison of Pre- and Post-Abortion Scores from Subscale #1 (Active Grief) t-Values of Paired Pre- and Post- Scores from Subscale #1 (Active Grief)

Category	Sub #1(pre)		Sub #2 (post)
Sample Size	30		30
Std. Deviation	10.3121		9.4966
Mean	40.7333		46.7667
Paired t-test	t-value	Degrees of Freedom	Critical t-value
	-4.6622	29	1.6991

Since the t-value of subscale #1 did not exceed the critical value calculated by this measure, the research data suggest that there is no significant difference in active grief pre-and post-abortion.

Table 5:
Comparison of Pre- and Post-Abortion Scores from Subscale #2 (Difficulty Coping) t-Values of Paired Pre and Post Scores from Subscale #2 (Difficulty Coping)

Category	Pre		Post
Sample Size	30		30
Std. Deviation	8.1731		6.3785
Mean	44.4000		48.9333
Paired t-test	t-Value	Degree of Freedom	Critical t-value
	-3.7208	29	1.6991

Since the t-value of subscale #2 did not exceed the critical value calculated by this measure, the research data suggests that there is no significant difference in difficulty coping pre-and post-abortion.

Table 6:
Comparison of Pre- and Post-abortion scores from Subscale #3 (Despair) t-Values of Paired Pre and Post Scores from Subscale #3 (Despair)

Category	Pre		Post
Sample Size	30		30
Std. Deviation	8.8837		7.5589
Mean	45.3333		48.0333
Paired t-test	t-value	Degree of Freedom	Critical t-Value
	-3.3705	29	1.6991

Since the t-value of subscale #3 did not exceed the critical value calculated by this measure, the research data suggests that there is no significant difference in despair at the time of the abortion and three weeks postabortion.

t-Test Analysis Results

Confidence level = 0.95 (One Tail Test)
full/pre vs. full/post

	FULL/PRE	FULL/POST		
Sample Size	30	30		
Number of Missing	0	0		
Minimum	57.0000	76.0000		
Maximum	162.0000	165.0000		
Standard Deviation	25.1406	21.4417		
Standard Error	4.5900	3.9147		
Coeff of Variation	19.2649	14.9246		
Mean	130.5000	143.6667	Difference =	-3.1667
Variance	632.0517	459.7471	Ratio =	1.3748
	t-Value	Probability	DF	Critical t-Value
Paired	-4.5305	4.66627E	29	1.6991
	Co-Variance	=419.2069	Std. Deviation	=2.9062

T-Test Analysis Results

Confidence Level = 0.95 (One Tail Test)
sub #1 pre vs. sub #1 post

	FULL/PRE	FULL/POST		
Sample Size	30	30		
Number of Missing	0	0		
Minimum	21.0000	24.0000		
Maximum	55.0000	55.0000		
Standard Deviation	10.1522	9.4966		
Standard Error	1.8535	1.7338		
Coeff of Variation	24.9850	20.3063		
Mean	40.6333	46.7667	Difference =	-6.1333
Variance	103.0678	90.1851	Ratio =	1.1428
	t-Value	Probability	DF	Critical t-Value
Paired	-4.8463	1.94426E-005	29	1.6991
	Co-Variance	=72.6011	Std. Deviation	=1.2656

t-Test Analysis Results

Confidence Level = 0.95 (One Tail Test)
sub #2 pre vs. sub #2 post:

	SUB #1 PRE	SUB #1 POST		
Sample Size	30	30		
Number of Missing	0	0		
Minimum	20.0000	32.0000		
Maximum	55.0000	55.0000		
Standard Deviation	8.1731	6.3785		
Standard Error	1.4922	1.1645		
Coeff of Variation	18.4079	13.0350		
Mean	44.4000	48.9333	Difference=	-4.5333
Variance	66.8000	40.6851	Ratio =	1.6419
	t-Value	Probability	DF	Critical t-Value
Paired	-3.7208	0.0004	29	1.6991
	Co-Variance	= 31.4759	Std. Deviation	= 1.2184

t-Test Analysis Results

Confidence Level = 0.95 (One Tail Test)
sub #3 pre vs. sub #3 post:

	SUB #3 PRE	SUB #3 POST		
Sample Size	30	30		
Number of Missing	0	0		
Minimum	16.0000	20.0000		
Maximum	55.0000	55.0000		
Standard Deviation	8.8837	7.5589		
Standard Error	1.6219	1.3801		
Coeff of Variation	19.5963	15.7368		
Mean	45.3333	48.0333	Difference =	-2.7000
Variance	78.9195	57.1368	Ratio =	1.3812
	t-Value	Probability	DF	Critical t-Value
Paired	-3.3705	0.0011	29	1.6991
	Co-Variance	= 58.4023	Std. Deviation	= 0.8011

The question, 'What did this abortion mean to you?' was included at the end of the Perinatal Grief Scale. The majority of women expressed positive reactions to the abortion and only a small minority expressed any degree of regrets as described below.

> 'I'm trying to put it behind me. I haven't felt right since the abortion - a little off kilter. I don't think about it much. When I do, I feel bad. It's hard to see babies. I know I will struggle with the decision I made for a long, long time. It's made me more compassionate toward other people, I think, more forgiving. But I can't imagine truly forgiving myself. I feel like a murderer sometimes, I really do.'

In general, five reasons were identified by women for the abortion choice including:

A.) A baby would interfere with work, school and/or other responsibilities.

> 'I can go on with my life and education. I don't have to worry about caring for an infant that I am not ready to.'
>
> 'It meant financial 'ease of burden' as well as less stress and worry for me. As a single mom who goes to school and works part time, I'd have been paying all my earnings out in child care expenses. Plus I'd not be able to focus enough attention on my education nor on my other two children. It means peace of mind; that I need right now.'

B.) Some women expressed financial considerations in choosing the abortion.

'I'm sorry that I had to do it. I should've had better birth control, but I'm so very glad I had it available. I'm low income and my 2 children are almost raised and we're just now climbing out of poverty, it would be an injustice to bring another child into a life of poverty.'

'There isn't the room, love or money for the fourth.'

B.) Not wanting to be a single parent or have problems in their relationships.

'It meant giving up a life and yet saving it at the same time. My boyfriend and I can't promise one another that we'll be together forever. I grew up with both a loving mother and father and so did he. We both agree it's not fair to bring a child into this world without being able to have the same life.'

"I have started new employment and have filed for divorce. I feel that there was no possible way I could keep the baby. The father is irresponsible and drinks a lot. I have two children from my marriage and was afraid of custody problems the new baby would have caused. It means that I can continue with the new job and excel in a field I love. It also means that I would not have a 'child' tying me with a man I didn't want to be with.'

D.) Too young to have a child;

"To me this abortion was a second chance. Because of my age I didn't feel ready to give birth and becoming pregnant changed a lot of my views. I never would have considered this choice had I not been so young and unable to be a good parent.'

E.) Having all the children she wanted;

'To carry on with my life at an age where I felt I did not want to start over again. I have 2 very healthy, much loved children and want to be there for them and to give them as much as I am capable of. They are my life. They are my joy. And to raise them in the best way I know how is the most important thing to me.'

'I feel I am too old to start over again with a new baby. I have 3 children ages 27, 18 and 8. I have been raising children long enough. I love the children I have with all my heart, but don't want anymore.'

The findings suggested a multiplicity of reasons for choosing an abortion. The multiplicity of reasons suggested that even if one specific problem would be solved it would not be enough to change most women's decision. All actual responses are included for information purposes (See Appendix D).

CHAPTER 6: SUMMARY AND CONCLUSIONS

This study included two hypotheses. Hypothesis #1: Women who elect to terminate their pregnancy will not experience a grief reaction. The full preabortion score on the Perinatal Grief Scale was not statistically significant. Therefore, the null hypothesis was accepted. Hypothesis #2: There would not be any significant difference in the mean Perinatal Grief Score at the time of the abortion as compared to the mean Perinatal Grief Score three weeks post-abortion. The research data support no significant difference in the mean score at the time of the abortion and the mean grief score three weeks post abortion. Therefore, the null hypothesis was accepted.

Discussion of findings

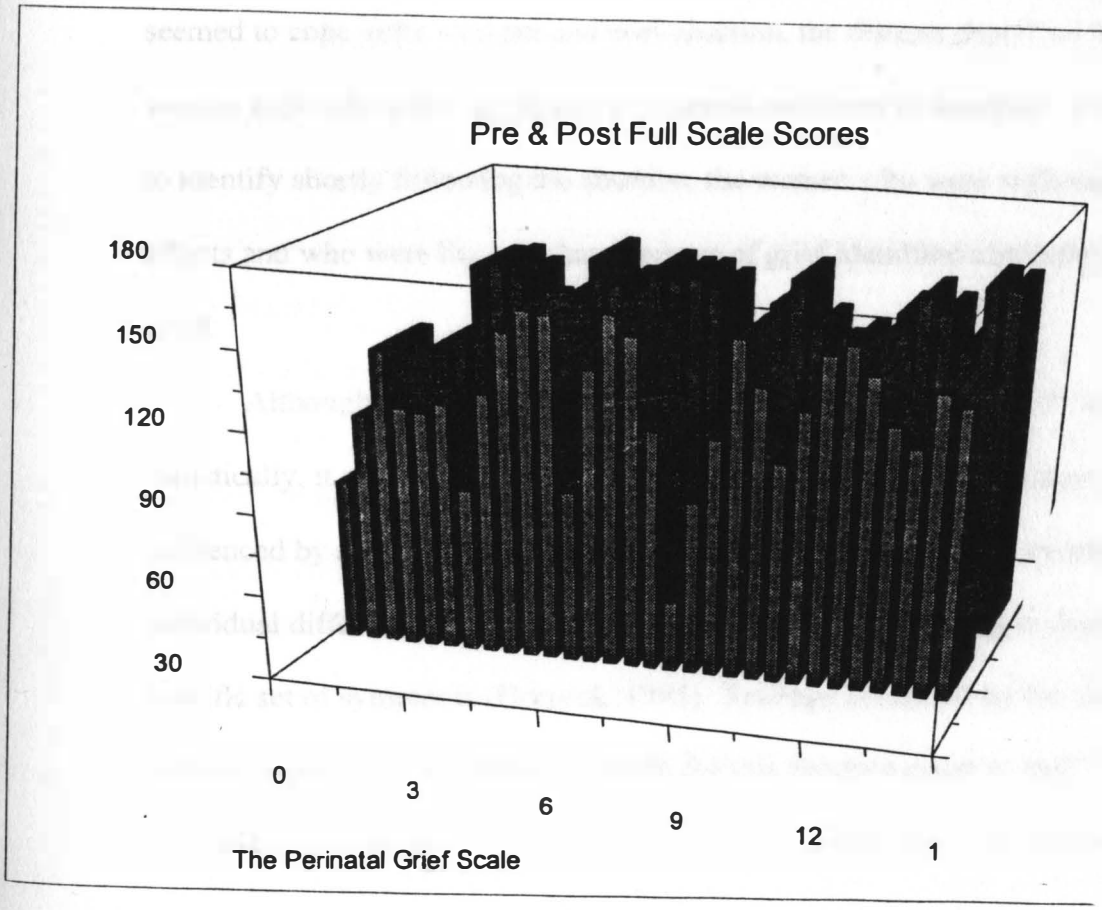
The present study provides preliminarily support to the hypothesis that women who elect to terminate their pregnancy will not experience a grief reaction. The hypothesis was developed to test the idea that acceptance of the pregnancy is necessary in the development of the maternal-infant bond. Election to terminate a pregnancy indicates a lack of acceptance. For those who cannot accept their pregnancy, the bonding process ceases. According to the maternal-infant bonding theory, grieving and bonding are irrevocably connected; there can be no grief without first having a bond (Kowaiski, 1987). Assuming that the decision to terminate a pregnancy indicated a lack of acceptance, high Perinatal Grief Scores would be anticipated.

The mean grief score for the pre-procedure response was 130.5 (the lower the score the higher the grief response, with possible scores ranging from 33 to 165). Pre-procedure scores ranged from 57 to 162. The wide variability in scores may indicate that some women have little difficulty prior to or subsequent to the abortion, while some women suffer degrees of perinatal grief.

There was no significant difference in the mean Perinatal Grief Score at the time

of the abortion as compared to the mean Perinatal Grief Score three weeks postabortion. The mean Perinatal Grief Score for the pre-procedure response was 130.5 (s.d. = 25.1406) as compared to 143.6 (s.d. = 21.4417). Pre-procedure scores ranged from 57 to 162 while the post-procedure scores had a range of 76 to 164 (see graph 2).

GRAPH 2
PRE & POST FULL SCALE SCORES
OF THE PERINATAL GRIEF SCALE



Each subscale (1) Active Grief, (2) Difficulty Coping, and (3) Despair was compared pre-abortion and three weeks post-abortion using the paired t-test. In each of the subscales, the t-value did not exceed the critical value. Therefore, it suggested no significant difference in any of the three subscales; Active Grief, Difficulty Coping, and Despair.

By examining the subscales and individual subject scoring, independently, it made it possible to distinguish women who were high on active grief from those who were high on difficulty coping or despair. Although the majority of women in this study seemed to cope quite well pre and post-abortion, the distress described by the minority of women highlighted the variability in personal responses to abortion. It was then possible to identify shortly following the abortion, the women who were suffering the most severe effects and who were likely to have aspects of grief identified clinically as pathological grief.

Although the question, "What did this abortion mean to you?" was not analyzed statistically, it was interesting to note the variety of responses. Because grieving is highly influenced by a number of historical and situational factors, there are numerous individual differences in the expression of grief. Active grieving is characterized by a specific set of symptoms (Horacek, 1995). Feelings described by the sample population in their response to the question, "What did this abortion mean to me?" displayed symptoms of acute grief including anxiety, guilt, nightmares, and feeling of loss.

Limitations

Given the moral, legal, and social controversy surrounding the issue of abortion, it

is quite conceivable that variables such as previous losses, age, religion and social issues may have an impact on the bereavement process of women who electively terminate their pregnancy. A limitation of this study was comparison only at pre-abortion and three weeks post-abortion utilizing the Perinatal Grief Scale. No comparison was made between variables and grief scores.

The scale selected for identifying perinatal grief in the abortion population may also have provided a limitation to this study. The Perinatal Grief Scale (Potvin, et al., 1989) was developed for research on pregnancy loss including spontaneous abortions, ectopic pregnancy, fetal death and neonatal death, but did not include elective termination. There are no scales developed specifically for research on elective terminations and bereavement.

The study was limited because it involved on a small cohort of women. Because of the small sample size, the perceptions of the women studied cannot be generalized to other women.

Another limitation of the study was the amount of time women were followed after the abortion. There was not sufficient time for long-term problems to surface or for differences between short term and long term problems to be identified.

Implications for further study

This study could be repeated longitudinally, comparing nonequivalent groups (adoption, induced abortion, spontaneous abortion) utilizing the Perinatal Grief Scale. Additional research is needed using larger sample sizes and other racial, cultural and socioeconomic groups.

Further studies in the area of grief following an abortion might include identifying variables that predict patients who demonstrate pathological grief following the abortion. Valid studies of the syndrome of delayed grief among women who have abortions need to

be developed and analyzed.

Conclusions

The very word abortion provokes intense emotions. Women selecting abortion have made an extremely difficult choice and therefore, face a uniquely painful type of loss.

The after effect of an abortion is often a sense of loss, without examining the moral logic. Various aspects of the abortion experience may contribute to distress; conflict about the meaning of abortion and its relation to deeply held values and beliefs, perceived social stigma or lack of support may induce negative reactions. Because grieving is highly influenced by a number of situational and historical factors there are great individual differences in how the grieving process unfolds.

The study showed no significant change in the Perinatal Grief Score at the time of the abortion and three weeks post-abortion. One may wonder if women electing to terminate their pregnancy experience grief at the time the decision was made. Another possibility is the social stigma attached to abortion and the thought that if women elect abortion, implying choice, they then lose the opportunity to openly grieve.

Assessment could be made on an individual level, responses to the Perinatal Grief Scale, looking at the individual subscales. One could identify women who have a greater-than-average risk of experiencing emotional distress following an abortion. The study was limited with respect to the time interval in which the effect was assessed and the small sample size utilized.

Implications for Advance Practice Nurses

Advanced Practice Nurses are key professionals in providing counseling to clients considering abortion. Clinicians must recognize that the attitudes toward abortion are varied and personal and that there are strong religious and moral influences in these

attitudes. One must respect the opinions and decisions of those involved.

Certain factors combine to make deciding to have an abortion and coping with its aftermath more difficult for some women than for others. These factors include strongly held personal values, an ambivalence about abortion, and excessive pressure from others. Advanced Practice Nurses should be attentive to indications that an abortion may create a period of crisis, requiring counseling and support. Referral to a professional counselor maybe indicated.

Nurses in advanced practice are in a position to provide anticipatory guidance to women who have experienced abortions. It is of utmost importance that the caregiver convey an unconditional acceptance of a woman's feelings and her grieving process. The major importance to the mourning process is the strength, support, acknowledgment of the grief by family, friends, and healthcare workers. Caregivers must help individuals undergoing the experience of abortion, aid in the comprehension that they have experienced losses and the perception of the reactions to grief and mourning.

Nurses in advanced practice must continue to increase their knowledge base as it relates to maternal grief. They must be able to recognize grief reactions and acknowledge the normalcy of the reactions. Advanced Practitioners will continue to be key advocates for women by providing education, support and counseling in bereavement and elective abortion. They must try to minimize human suffering by informing, accepting, understanding and supporting women as they make and live with reproductive choices in context to their own circumstances.

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Appendix A

DEMOGRAPHIC INFORMATION
Please circle the appropriate component in each category.

AGE

18-22
23-27
28-32
33-37
>38

ETHNIC HERITAGE

African - American
Asian - American
European - American
Hispanic - American
Native- American

MARITAL STATUS

Married
Separated
Divorced
Widowed
Never-married

RELIGION

Protestant
Catholic
Jewish
Other
None

EDUCATION

8th grade or less
9th - 11th grade
HS graduate or GED
Some college
College graduate

ENROLLED IN SCHOOL

Yes
No

CURRENTLY EMPLOYED

Yes
No

FAMILY INCOME

<$15000
$15000-$29999
$30000- $59999
>$60000

MEDICAID COVERAGE

Yes
No

STATE OF RESIDENCE

Montana
Nebraska
North Dakota
South Dakota
Wyoming
Other

COUNTY OF RESIDENCE

GYN HISTORY

1st pregnancy
Prior term birth
Prior miscarriage
Prior elective abortion

No. of live births
1
2
3
4 or more

WEEKS OF GESTATION

Less than 7
8-10
11-13

CONTRACEPTIVE METHOD USED AT THE TIME OF CONCEPTION

Sterilization
Implant
Intrauterine device (IUD)
Injectable
Pill
Condom
Female Condom
Sponge
Foam
Suppository
Periodic Abstinence
Withdrawal
Other
None

APPENDIX B
CONSENT FORM
PROJECT: BEREAVEMENT IN THE ELECTIVE TERMINATION PATIENT

RESEARCHER: Nancy E. Brown

The nature of this research project has been explained to me. I understand the purpose of this project is to gather information concerning the bereavement process in the elective termination population. I understand that my participation involves filling out the Perinatal Bereavement Scale at the time of my abortion and then again at three weeks post abortion. My rights regarding participation have also been explained to me. I realize that all information will remain confidential and my identity will be safe-guarded. I understand that the results of the study, published or unpublished, will in no way identify me. I hereby give my consent to participate in this study and I will receive a copy of this signed consent form. I fully understand that my signature signifies I give my consent to participate and I have in no way been coerced.

_____

Name

_____

Date

Dear Participant:

I am conducting a study entitled "Bereavement in the Elective Abortion Patient" as a part of the thesis requirement at South Dakota State University.

The purpose of the study is to determine if women who elective abortions grieve.

You as a patient are invited to participate in the study by completing the attached Perinatal Bereavement Scale. I realize that your time is valuable and have attempted to keep the requested information as. brief and concise as possible. It will take you approximately ten minutes to complete the survey. Your participation in this project is voluntary.

Risks to your participation in the study may include emotional responses to certain questions. If questions are of a sensitive nature, please attempt to answer them to the best of your ability. You may be referred for counseling upon your request.

Your responses are strictly confidential. When the data are presented in a written report, you will not be linked to the data by your name, title or any other identifying item.

If you have any questions, now or later, you may contact me at the number below. Thank you very much for your time and assistance.

Sincerely,

Nancy Brown, MSN student
313 S Melrose
234-7363

APPENDIX C

Perinatal Grief Scale

Each of the items is a statement of thoughts and feelings which some people have concerning a loss such as yours. There is no right or wrong response to these statements. For each item, circle the number which best indicates the extent to which you agree or disagree with it at the present time. If you are not certain, use the 'neither' (#3) category. Please try to use this category (#3) only when you truly have no opinion.

1 = strongly agree 2 = agree 3 = neither agree or disagree
4 = disagree 5 = strongly disagree

1. I feel depressed.	1	2	3	4	5
2. I find it hard to get along with certain people.	1	2	3	4	5
3. I feel empty inside.	1	2	3	4	5
4. I can't keep up with my normal activities.	1	2	3	4	5
5. I feel a need to talk about the abortion.	1	2	3	4	5
6. I am grieving for the pregnancy.	1	2	3	4	5
7. I am frightened.	1	2	3	4	5
8. I have considered suicide since the abortion.	1	2	3	4	5
9. I take medicine for my nerves.	1	2	3	4	5
10. I very much miss the pregnancy.	1	2	3	4	5
11. I feel I have adjusted well to the loss.	1	2	3	4	5
12. It is painful to recall memories of the loss.	1	2	3	4	5

13. I get upset when I think about the abortion.	1	2	3	4	5
14. I cry when I think about the abortion.	1	2	3	4	5
15. I feel guilty when I think about the embryo.	1	2	3	4	5
16. I feel physically ill when I think about the embryo.	1	2	3	4	5
17. I feel unprotected in a dangerous world since the abortion.	1	2	3	4	5
18. I try to laugh, but nothing seems funny anymore.	1	2	3	4	5
19. Time passes so slowly since the abortion.	1	2	3	4	5
20. The best part of me died with the embryo.	1	2	3	4	5
21. I have let people down since the abortion.	1	2	3	4	5
22. I feel worthless since the abortion.	1	2	3	4	5
23. I blame myself for the embryo's death.	1	2	3	4	5
24. I get cross at my friends and relatives more than I should.	1	2	3	4	5
25. Sometimes I feel like I need a professional counselor to help me get my life back together again.	1	2	3	4	5
26. I feel as though I'm just existing and and not really living since the abortion.	1	2	3	4	5
27. I feel so lonely since the abortion.	1	2	3	4	5

27a. I feel a need to talk about the abortion.	1	2	3	4	5
28. I feel somewhat apart and remote, even among friends.	1	2	3	4	5
29. It's safer not to love	1	2	3	4	5
30. I find it difficult to make decisions since the abortion.	1	2	3	4	5
31. I worry about what my future will be like.	1	2	3	4	5
32. Being a bereaved parent/patient means being a 'second-class citizen'.	1	2	3	4	5
33. It feels great to be alive.	1	2	3	4	5

Please answer the following question.

WHAT DID THIS ABORTION MEAN TO YOU?

33 ITEM PERINATAL GRIEF SCALE

The following three subscales comprise the grief total for the 33 item scale. Each column lists the subscale number and name and the item number that make up that subscale. Items marked (R) must be reversed in scoring.

Subscale 1 Active Grief	Subscale 2 Difficulty Coping	Subscale 3 Despair
1	2	9
3	4	15
5	8	16
6	11 (R)	17
7	21	18
10	24	20
12	25	22
13	26	23
14	28	29
19	30	31
27	33 (R)	32

Empirical subscale scores range from 11 to 55, with the lower scores indicating higher levels of grief.

r = Reversal of items

APPENDIX D

Answers to the question;

WHAT DID THIS ABORTION MEAN TO MEAN?

1. #1 = It meant that I would be able and healthy to take care of my other two children, since I do it all on my own.

   #2 = Help to know I'm healthy and can provide the best for my children.

2. #1 = Confusion. Questions run through my mind if this is really the best decision for me or what this child would have meant for me. The other side of the confusion is how could I possibly afford another child in my life right now. Would my financial situation change my decision and the way I provide for my family now? I feel guilty but I also feel that my decision shows responsibility for my existing children.

   #2 = A second chance to make my life what I need it to be. A fresh start. To get my life in control.

3. #1 = It meant giving up a life and yet saving it at the same time. My boyfriend and I can't promise one another that we'll be together forever. I grew up with both a loving mother and father and so did he. We both agree it's not fair to bring a child into this world without being able to have the same life. I see my best friend raise her child by herself and it hurts them both not to have the father around. I refuse to put another child thru this. I have plans of college and a full life, when I am capable of giving a child all it needs then I will have one. I know the decision I made was right for me and my baby.

   #2 = It meant being able to go on with my life knowing that later I could have a child and be able to give it everything a child needs. I was unable to do this at this time and it was better for everyone involved.

4. #1 = To carry on with my life at an age where I felt I did not want to start over again. I have 2 very healthy, much loved children and want to be there for them and to give them as much as I am capable of. <u>They are my life. They are my joy.</u> And to raise them in the best way I know how is the most important thing to me.

   #2 = No response, except "I'm doing great"

5. #1 = I have started new employment and have filed for divorce. I feel that there was no possible way I could keep the baby. The father is irresponsible and drinks a lot. I have two children from my marriage and was afraid of custody problems the new baby would have caused. It means that I can continue with the new job and excel in a field I love. It also means that I would not have a 'child' tying me with a man I didn't want to be with.

#2 = The father has played psychological games since and I am very grateful to not put an innocent child through the torment he has caused me.

6. #1 = I have a 10mo old baby who helps me get through all of this, I'm also a recent patient of back surgery and advised not to go through with the pregnancy. These all help me make may decision.

#2 = No response.

7. #1 = This abortion was a 2nd chance for me. It sounds selfish, but I find it hard to ruin my entire life over one stupid mistake. Had I been older this option would have never been considered.

#2 = To me this abortion was a second chance. Because of my age I didn't feel ready to give birth and becoming pregnant changed a lot of my views. I never would have considered this choice had I not been so young and unable to be a good parent.

8. #1 = I'm sorry that I had to do it. I should've had better birth control but I'm so very glad I had it available. I'm low income and my 2 children are almost raised and we're just now climbing out of poverty, it would be an injustice to bring another child into a life of poverty. Abortion should stay legal and there should be wonderful doctors like mine who care enough to do them right.

#2 = I guess I'll admit that I am having dreams about babies holding their arms out to me asking for their mother. But not to often. Actually besides that I feel like I've adjusted well. I am very leary of getting pregnant again. As of now 'sex' doesn't sound that great. but I think it's the man I was involved with. I'm glad I had the abortion for a lot of reasons. Financial reasons, not being sure about the father, I felt like he could've been a little on the perverted side towards children. Also because my 2 kids are almost raised, etc. I think its natural for any good hearted woman to have some of the guilt feelings I'm

having and still at the same time know that it was the best thing to do. I'll be ok, it was for the best!

9. #1 = No response
#2 = No response

10. #1 = It was a minor set back and now I can get back on track, looking forward to what the future holds for me.

#2 = It meant putting aside a minor setback and getting on with my life.

11. #1 = No response
#2 = No response

12. #1 = I'm waiting to have it right now so I'm not sure yet. What it means to me at this point is a sacrifice for my other children and for me - I knew I could not possibly handle another baby, working full time single mom, etc. I made a stupid mistake I'll never make again. Any residual feelings of guilt, remorse, etc. I'll just have to deal with - I feel a need to punish myself for a while, to feel like I don't deserve to be happy or have fun. I hope that goes away.

#2 = I'm trying to put it behind me. I haven't felt right since the abortion - a little 'off kilter'. I don't think about it much. When I do I feel bad. It's hard to see babies. I know I will struggle with the decision I made for a long, long time. It's 'made me more compassionate toward other people, I think, more forgiving. But I can't imagine truly forgiving myself. I feel like a murderer sometimes, I really do.

13. #1 = I feel that a life is being lost. But I can't afford another baby and I can't bear the thought of someone else raising him/her.

#2 = This abortion was the right thing to do. I don't feel guilty and I don't regret anything. I know I was taking a life, but there was no possible way I could raise another child. I am very confident with my decision.

14. #1 = It meant I was not bringing something into this world that I couldn't handle. I wasn't ready for another child or another pregnancy. I feel if I would have kept the baby I would have resented the baby and myself.
#2 = No response

15. #1 = It means a life for me and my son.

#2 = No response

16. #1 = I did what I thought was in the best interest of the unborn child. And my child who is living now. I am a single mother struggling to get by with one child. I could not consider going thru the pregnancy and giving a child up for adoption either. It was a difficult thing to do anyway you look at it.

#2 = I felt badly, but I realize it was the best choice considering my life, and the way it is. I already have one small child and I am single trying to raise him alone which is very difficult at times.

17. #1 = No response

#2 = A lot of hurt, pain and failure. Loss of trust in myself and others.

18. #1 = To always be more careful. Don't take life for granted. Think before you act. I feel in a way selfish, but I also feel this is better because my baby wouldn't have had the life it deserved.

#2 = Don't take life for granted. Always be safe and careful.

19. #1 = This was by no means a method of birth control. At this time it is hard enough to support the child I have let alone another one. At this point, I have a hard time trusting men when it comes to my daughters future and my own. I don't like being a single parent, and don't believe that a child is the two people should be together. This is quite a lesson to learn and a very hard decision, but I believe we have made the right one.

#2 = It wasn't a form of birth control! I am a single parent and struggle enough with one child. I want to be able to give her all she need!

20. #1 = No response

#2 = It means doing something right for me and what would have been my kid. I don't want kids till I'm married and I could not afford it right now. Life would have been very depressing for me if I would have had the kid.

21. #1 = I can continue on with my life. It's relief that I don't have to care for a child that I am not prepared for.

#2 = I can go on with my life and education. I don't have to worry about caring for an infant that I am not ready to.

22. #1 = Relief, but also a lot of guilt.

#2 = It meant being able to finish my school since I couldn't go while pregnant because of the chemicals, so I pretty much feel the same as before, which was relief but still a whole lot of guilt. It makes me feel kind of bad about myself, but I think it was the right decision because I don't want anymore children and can't afford anymore at this time. Since the abortion I am very emotional and find myself crying at small things. Hopefully in time I can try to leave it behind me. Thanks.

23. #1 = Sad that it had to happen in the first place, but I felt I had no choice and it was the best decision for me and my life.

#2 = sad thing that had to be done

24. #1 = absolutely nothing. Not true. A lesson in life I hope I have learned the second time around. I have three beautiful children. There isn't the room, love or money for the fourth. I feel I made the smart choice.

#2 = I have an 18 month old to an 8 year old. I feel that I made the best choice.

25. #1 = No response

#2 = An objective decision was made, I thought about certain consequences; timing, job, marriage and want to be a mom at home with my children when I have one. This is my body, my decision, and I feel I am the one that must deal with the consequences. I am more pro-choice.

26. #1 = I feel I am to old to start over again with a new baby. I have 3 children ages 27, 18 and 8. I have been raising children long enough. I love the children I have with all my heart, but don't want anymore.

#2 = We do not want any more children.

27. #1 = It meant financial 'ease of burden' as well as less stress and worry for me. As a single mom who goes to school and works part time, I'd

have been paying all my earnings out in child care expenses. Plus I'd not be able to focus enough attention on my education nor on my other two children. It means peace of mind; that I need right now.

#2 = This abortion still means financial security, as far as I would not have been able to provide well for the baby. I would have been under great pressure to have to provide for day care and medical costs. Plus, I feel as though my older kids would have felt slighted (almost) by the restrictions a baby would have placed on our lifestyles. I did make the right decision with this procedure.

28. #1 = Without this abortion, my family (mother, father, sister) would disown me.

#2 = No response

29. #1 = I didn't feel that I could handle another child at this time and in order to be fair to myself and the unborn child I though this over very carefully. To me this abortion was thought out and I feel that I am doing the right thing.

#2 = No response

30. #1 - No response

#2 = No response

APPENDIX E

Lehigh University

Center for Social Research
telephone (610) 758-3800

516-520 Brodhead Avenue
Bethlehem, Pennsylvania 18015-3051

April 27,1995

Ms. Nancy Brown
4710 South David Street
Casper, Wyoming 82601

Dear Ms. Brown:

Enclosed, is the PGS packet you requested along with a list of additional publications and papers. We would be happy for you to use our scales for your research.

We also look forward to seeing your results.

Sincerely,

Judith A. Lasker

Lori J. Toedter

APPENDIX F

October 1, 1997

Nancy E. Brown
471 0 S. David
Casper, WY. 82601

Dear Ms. Brown:

Thank you for submitting your thesis proposal, BEREAVEMENT IN THE ELECTIVE ABORTION POPULATION. I look forward to reviewing the final document.

I give you permission to utilize my clinic and the population that we serve. If I can be of further assistance with your thesis, please do not hesitate in calling.

Sincerely,

Goode Cheatham, MD
313 S. Melrose
Casper, WY. 82601

307-234-7363

cc: file

South Dakota
State University

Graduate School
Office of Research
Grants Administration Office

Box 2201, Admin. 130
SDSU
Brookings, SD 57007-1998
Phone 605-688-4181
FAX 605-688-6167

Date: September 19, 1997

To: Nancy Brown 471 0 S. David Casper, Wyoming 82601

From: David Hilderbrand, Acting Director of Research

Subject: Expedited Human Subjects Committee Action on Proposal Entitled, **"BEREAVEMENT IN THE ELECTIVE ABORTION POPULATION."**

The above proposal has been reviewed and approved by members of the Human Subjects Committee.

Please notify the Office of Research when this project is completed. Should you find that the study will last longer than your projected date of 10/30/97, a progress report and request for extension must be filed with the Office of Research prior to the end of the project period. A form to assist you in filing your completion and/or progress report is included in the Policies and Procedures Packet which you received earlier.

If you have any questions, please contact me.

Good luck on your study.
ddr
Copy: Dr. Penny Powers
1011 11th St.
Rapid City, SD 57701

Dean Roberta Olson
NFA 255/2275

October 10, 1997

David Hilderbrand
Acting Director of Research
Graduate School
Office of Research
Box 2201, Admin. 130
SDSU
Brookings, S.D. 57007-1998

Dear Mr. Hilderbrand:

I have received official notice of approval from the Human Subjects Committee to continue with my research entitled, "BEREAVENMENT IN THE ELECTIVE ABORTION POPULATION-. The letter of approval arrived September 25. 1997.

1 am writing to inform you that the original study was to begin August 1, 1997 and be completed in a three month period or on conclusion of sixty participants. Having received notice at the end of September,. the study began officially on October 1. 1997. It will conclude at the end of the three month period as proposed or on conclusion of sixty participants (January 1, 1998).

If you have concerns or questions to this matter, I will be happy to address them. You may reach me at my home number 307-266-0124.

Thank you for your time and concern to this matter.

Sincerely.

4710 S. David
Casper, Wy. 82601

307-266-1024

Copy: Dr. Penny Powers