INDUCED ABORTION AMONG A GROUP OF BLACK SOUTH AFRICAN WOMEN: AN EXPLORATORY STUDY OF FACTORS INFLUENCING SHORT-TERM POST-ABORTION ADJUSTMENT

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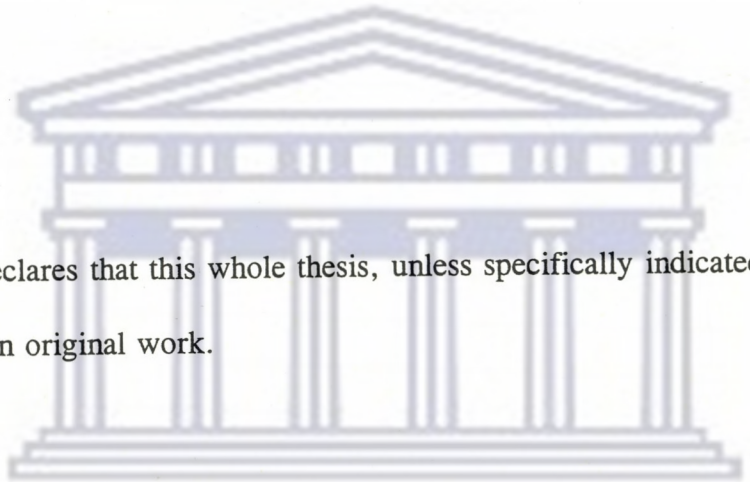
ABSTRACT

Throughout recorded history, women have resorted to abortion to terminate unwanted pregnancies, despite religious and legal sanctions, and frequently at significant personal risk. Abortion is, therefore, one of the oldest and at the same time most controversial of approaches to fertility control. More than most procedures, abortion is embedded in a social context that has implications for psychological responses of women. However, whilst South Africa's restrictive abortion legislation has come to the forefront of public scrutiny in recent years, research on the psychological aspects of induced abortion among black South African women has received minimal attention from social science researchers. This consideration requires redress since South Africa's abortion policy has undoubtedly had an impact on black women's mental health. Although unwanted pregnancy and the decision to abort are frequently perceived as stressful, evidence to date suggests that women do not experience severe negative reactions to abortion. Nevertheless, research has shown that some women do experience negative reactions following abortion. The responses of these women, placed within the context of the large numbers of black women who procure abortions and the immense social significance of the issue, point to a need to identify those women who are at risk for experiencing difficulties after abortion. This thesis, therefore, aimed to explore women's interpretations of the factors that influence short-term post-abortion adjustment. Five women who had procured illegal abortions were interviewed. A thematic analysis was utilised to explore participants' accounts of their abortion experiences. Furthermore, the present inquiry attempted to identify, through participants' discourses, psycho-social factors that may serve as 'risk factors' for poor post-abortion adjustment. The findings revealed that the abortion experience varies in the amount and type of stress it engenders for women. The manner in which these women responded to the

procedure was found to be a joint function of their psychological state and of the social milieu in which the abortion occurred. Participants' post-abortion adjustment was found to be significantly influenced by the extent to which they experienced decision difficulty, the nature of the social environment surrounding the abortion process and individual coping responses. Thus, the findings of the study accentuate the need for counselling interventions designed to facilitate adjustment to abortion. These issues are likely to become of increased importance as the South African government deliberates on its public policy on abortion.

DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.



SHAHNAAZ SUFFLA

DEDICATION

To

The memory of

Jeff

Who touched my life so deeply,

Who taught me about love, life and death.

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CHAPTER ONE

INTRODUCTION

Research on the psychological aspects of reproduction has increased greatly during the last few decades. Inquiry into this area has been spurred on by the development of important new reproductive technologies, wide-spread concern about over-population, and major changes in both gender-role expectations and actual gender-role behaviour (Miller, 1992). For a variety of reasons, however, research on the psychological aspects of induced abortion has not kept pace with the work done in other domains of reproduction, especially in countries like South Africa where access to safe abortion services is legally restricted. Most important among these reasons have been the subtlety and considerable sensitivity of abortion psychology and the growing politicisation of the entire subject of abortion.

Present legislation in South Africa, the Abortion and Sterilisation Act of 1975, excludes the majority of women from seeking legal abortion. The Act, which criminalises induced abortion in all but a few restricted circumstances, has forced many women to seek 'back-street', or illegal, abortions (Dyer, 1995). Some 200 000 to 300 000 illegal abortions are estimated to take place in South Africa each year (Cooper, Hamilton, Mashabela, Mackay, Sidiropoulous, Gordon-Brown, Murphy & Frielanghaus, 1994). For many women, especially the economically and socially disadvantaged, this lack of reproductive freedom has had major physical, social and mental health implications.

In her analysis of the theoretical implications of a feminist view of reproductive freedom, Petchesky (1984) argued that reproductive freedom is social and individual at the same time: 'it operates at the core of social life as well as within and upon women's individual bodies' (p. 2). Comparable to this position, psychological researchers, who are increasingly involved in debates regarding abortion, assert the perspective that abortion is embedded in a social context that has implications for psychological reactions of women (e.g., Adler, 1979; David, 1985; Major & Cozzarelli, 1992; Miller, 1992; Speckard & Rue, 1992).

A social-psychological framework has been suggested which views abortion as a stress experience. The American Psychological Association (APA) recently concluded that abortion is not likely to be followed by severe psychological responses and that psychological aspects can best be understood within a framework of normal stress and coping rather than a model of psychopathology (Adler, David, Major, Roth, Russo & Wyatt, 1990, 1992). This conclusion is based on studies, conducted on post-abortion responses, which reveal that abortion does not pose a significant short-term hazard for most women (Adler et al., 1990), and that post-abortion adjustment typically improves over time (Mueller & Major, 1989). Nevertheless, the fact that some research reveals that a small minority of women experience negative psychological responses such as depression, anxiety, guilt or regret after having an abortion (Wilmoth, de Alteriis & Bussell, 1992) pointed to a clear need to further identify which women might be at risk for negative post-abortion consequences.

However, even though abortion has been a part of the South African way of life for the last 150 years (Bradford, 1991), it is only in relation to maternal mortality that abortion has received significant attention in Africa (Coeytaux, 1988; Rogo, 1993). In spite of the recent national

prominence of the pro-life/pro-choice debate, abortion research in South Africa has neglected to investigate psychological factors associated with abortion. To date, there has been no large-scale, national study on the emotional experience of abortion. Previous research has been largely quantitative in nature and limited almost exclusively to the collection of epidemiological and demographic data from women who have obtained non-restrictive, and therefore legal, abortions. A high proportion of these abortions are performed on white women (Rees, 1991). This absence of qualitative data on the psychological outcomes of abortion is striking in a country where thousands of black women undergo abortions each year. It is, therefore, recognised that there is a general paucity of in-depth, qualitative research among black women who have had induced abortions, that is, who have terminated a pregnancy illegally.

Accordingly, the principal focus of the present study is to explore black women's experiences of induced abortion through qualitative inquiry. More specifically, the study aims to explore participants' accounts of the factors that influence short-term post-abortion adjustment. Consequently, the investigation also aims to identify, through participants' discourses, psycho-social factors that may serve as 'risk factors' for poor adjustment following abortion. A central aim underlying this investigation is the exploration of lay-peoples' interpretation of social reality.

The present investigation into abortion outcome contributes to an understanding of the complexities and nuances of the abortion experience in South Africa. Findings offer insights into the dominant discourses employed by black women to interpret their abortion experiences. This has implications for clinical practice, namely that women who are identified as being at risk for short-term distress following induced abortion may benefit from counselling interventions designed to facilitate adjustment to abortion. The data may also contribute to public policy and

debate on restrictive legislation which is sometimes justified on the grounds of a deleterious psychological outcome to induced abortion. This chapter is concluded with an outline of the remaining chapters.

Chapter Two presents a review of the literature that is relevant to the aims of the present study. It examines the socio-political context in which illegal abortion occurs in South Africa, it focuses on the outcomes of studies on women's post-abortion emotional responses and it identifies theoretical frameworks that have been employed in research of this nature.

Chapter Three considers the methodological issues pertinent to the present study. A detailed argument for the utility of the qualitative paradigm is offered. This discussion encompasses a critique of the quantitative approach to social science research as well as a methodological critique of studies on abortion specifically. In addition, the aims, participants, use of interviews, data gathering procedures and method of analysis for the current study are detailed. Finally, this chapter offers a statement of ethical considerations.

Chapter Four is a report on women's accounts of their abortion experience. It identifies and interprets the personal meanings that the women attached to their abortion experiences.

Chapter Five summarises the findings of the present inquiry and explores their significance. It identifies the limitations of the study and concludes by generating recommendations for future research in this area.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Throughout recorded history, women have resorted to abortion to terminate unwanted pregnancies, despite religious and legal sanctions, and frequently at significant personal risk. It has been observed that although universally practised, no other elective procedure has 'evoked as much divisive political debate, generated such emotional and moral passion, or received greater sustained attention from the media' (David, 1993, p. 593).

South African society is increasingly involved in debates regarding abortion. Whilst there is growing acknowledgement that abortion is associated with a wide range of psychological and social issues, there has been a paucity of research on induced abortion in South Africa, and its implications for women. While recognising the diversity of ethical and moral, economic, medical and larger social issues intertwined with abortion, the present study focused on psychological factors associated with abortion, since this continues to be a neglected area in abortion research in South Africa. More specifically, the aim of the study was to explore factors that influence short-term post-abortion adjustment.

As background to the present study, it was considered important to contextualise abortion practices in South Africa in order to highlight current debates on the abortion issue. Furthermore, this section provides a review of research evidence on psychological sequelae to

induced abortion. Therefore, this chapter will firstly examine the history and status of abortion in South Africa. Secondly, it will review the research literature on post-abortion emotional responses with specific reference to normative responses to abortion, psychosocial factors related to adjustment to abortion and theoretical frameworks underlying abortion research.

2.2 History and Status of Abortion in South Africa

Abortion is a universally practised but by no means universally approved procedure. The legitimacy of the act varies according to religious and scientific evaluations of foetal life, sexual mores, state population policies, the circumstances of conception and the status of the woman involved. Society's attitudes to abortion, therefore, reveal anxieties about the family, sexuality, secularism, the birth rate and shifting gender roles (Cope, cited in Fedler, 1994; Gray, 1980; Rees, 1991; Sarkin-Hughes, 1993). Both the current legal strictures on abortion, as well as the movement towards abortion reform in South Africa reflect tensions around these issues.

2.2.1 Legislation

Until 1975, abortion was prohibited in South Africa, except in situations of absolute necessity (Rees, 1991). An abortion would only be granted if the woman's life was placed at risk through continuation of the pregnancy. On 12 March 1975, the Abortion and Sterilisation Act, No. 2 of 1975 (Statutes of the Republic of South Africa, 1975, see Appendix B) was instituted. This is the legislation that defines the circumstances under which an abortion may be procured by a woman.

The Act allows for an abortion where :

a) continued pregnancy would endanger the life of the woman concerned or constitute a serious threat to her physical health;

b) continued pregnancy would constitute a serious threat to the mental health of the woman concerned;

c) there is a serious risk that the child will suffer from a serious physical or mental defect that would lead to irreparable handicap;

d) the pregnancy has resulted from rape or incest;

e) the pregnancy is conceived by a woman who is mentally handicapped or unable to understand the full implications of parental responsibility.

2.2.2 Effects of the 1975 Abortion and Sterilisation Act

The Abortion and Sterilisation Act prevents the majority of South African women from obtaining a legal abortion (Chubb, 1993; Dyer, 1994; Gray, 1980; Rees, 1991). Rees (1991) estimated that approximately 40% of applications for legal abortions are successful each year; the majority of successful applicants being white women. Only 868 legal abortions were performed in South Africa in 1990; nearly 69% on white women (Dyer, 1991). The majority of legal abortions performed annually are based on psychiatric grounds (Rees, 1991). Dyer (1993) stated that this is in stark contrast to countries with liberal legislation where the mental stress of an unwanted pregnancy is accepted as reason for abortion without the requirement that 'the continued pregnancy creates the danger of permanent damage to the woman's mental health' (p. 2). In addition, the private health sector, understanding that there is a demand for abortions that the state health sector cannot meet, has found legal avenues to grant women abortions. For

example, in 1988 one private clinic in Johannesburg performed 257 abortions, 241 of which were performed on psychiatric grounds (Rees, 1991). This service is restricted to the economically advantaged and predominantly to white women. The Act has been criticised for barring impoverished black women from having easy access to legal abortions (Cope, cited in Fedler, 1994).

One problem with developing restrictive abortion policies is the discrepancy between policy-maker's assumptions and the realities of women's lives. Regardless of the present highly restrictive abortion laws, many South African women of all ethnicities and social classes continue to terminate unwanted pregnancies through 'back-street' or illegal abortions (Maforah & Wood, 1995; Rees, 1991). It is estimated that 200 000 to 300 000 illegal abortions are performed in South Africa each year (Cooper et al., 1994). The vast majority of these operations are performed on poor black women (Dyer, 1995). Accurate statistics are difficult to ascertain because of the illegality of 'back-street' abortions. Nonetheless, it is clear that the Abortion Act has failed in its aim to control and restrict the total number of abortions being performed in South Africa year after year. According to Makatini (1993) the figures reflect that failure by some sections of South African society to acknowledge a woman's right to the control and autonomy over her body does not stop her from exercising it. Coeytaux (cited in Sweetman, 1994) pointed out that no society has been able to eliminate induced abortion as an element of fertility control.

It has been stressed that the physical effects of restrictive abortion legislation on the lives of women are far-reaching and destructive (Cope, cited in Fedler, 1994; Sarkin-Hughes, 1993). Dyer (1994) has emphasised that women have suffered from a law which, by restricting their

right to control their reproductive lives, has also restricted their right to good health. At a recent International Planned Parenthood Federation conference on Unsafe Abortion and Post-abortion Family Planning in Africa, it was concluded that in most African countries abortion laws are restrictive, with illegally induced unsafe abortions a major cause of maternal mortality and morbidity and hence a significant and growing public health problem (Dyer, 1994). Women from African countries have the second largest incidence of illegal abortions in the world (Dyer, 1992). Participants at the conference noted with concern that almost 10 000 African women undergo unsafe abortions every day, and many of these women suffer illness, infertility and even death as a result. In South Africa the rate of maternal mortality as a result of abortion is 7 per 100 000 for white women, and 24 per 100 000 for black women (Dyer, 1991). In addition, at one hospital alone approximately 15 000 patients are admitted each year with infections that are associated with non-legal abortions (Rees, 1991).

From a socio-economic perspective, Sarkin-Hughes (1993) argued that the damaging effects of poor health upon women's employment undermine their attempts to establish economic stability for existing family structures. Pregnancy, both planned and unplanned, places rigid restrictions on women's employment opportunities, impeding their ability to support their families. The recent World Bank poverty survey (Women's Health Project, 1995) concluded that women bear the burden of poverty. As a result, it has been emphasised that the financial burdens are disproportionately detrimental for poor women who, in South Africa, are primarily black women (Makatini, 1993; Sarkin-Hughes, 1993).

According to Sarkin-Hughes (1993, p. 87):

> Denying women moral independence as decision-makers affects the physical, social, financial and psychological position of women far more than it significantly affects the number of women choosing to have an abortion.

However, the psychological effects of the present Act, which criminalises abortion, have yet to be established. It is not known whether psychological effects vary in accordance with different legislature on abortion. The present study aimed, in part, to explore this question.

2.2.3 Responses to Present Abortion Legislation

In a socio-historical analysis of abortion practices in South Africa, Bradford (1991, p. 120) stated that:

> In a society disfigured by female economic and political subordination in general, and by controls over female fertility and sexuality in particular, abortion was (and still is) a site of struggle.

Although it is not strictly within the aims of this study, it is believed that an examination of this 'struggle' and its social manifestations is crucial to understanding fully the abortion experience in South Africa. Public discourse on abortion is considered to be a significant aspect of the personal experiences of individual women undergoing abortion (Wilmoth, 1992). The abortion experience can best be understood by examining it in the context in which it occurs (Baker & Khasiani, 1992). Here, context refers to both women's personal situations, as well as the larger socio-political setting in which induced abortion occurs. Since the two are inherently connected,

a brief review of socio-political responses to induced abortion in South Africa will be offered.

Abortion policy is presently a matter of intense debate in South Africa. The debate is dominated by two groups of activists; 'anti-abortion' (anti-choice) groups and 'pro-abortion' (pro-choice) groups. The former advocate restrictive policies and the latter advocate a permissive policy that allows a woman to have reproductive choice. In her review of these two positions Rees (1991) found that the core argument against abortion is that life is present from the time of fertilisation, and that this life must be preserved at all costs. The argument holds that abortion should not be allowed under any circumstances because it is against society's moral and religious principles. To continue with the pregnancy and place the child for adoption is considered to be an acceptable alternative. Rees (1991) highlighted that the pro-abortion lobby argues both from a political position and from a more pragmatic point of a view. From a political level they argue that the entire economic structure of South Africa is patriarchal. The women's role is to serve men, to provide cheap labour in the work-place, to bear children and to rear them and to keep the home functional. If this position is to be challenged, then they must be able to choose when, and if, they want to have children. Pro-abortionists consider abortion as a vital part in this liberation. On a more pragmatic level, they believe that despite restrictive laws attempting to regulate their reproductive rights, women are having abortions anyway, and therefore the abortion law should be amended so that thousands of women are no longer criminalised and placed at risk in terms of their health (Rees, 1991).

In 1980 and 1990, research was done on the attitudes of South African gynaecologists to the present Abortion and Sterilisation Act of 1975 (Dommisse, 1980, 1990). The proportion of respondents favouring abortion on demand in the first trimester increased from 32% to 40%

over this period, while that of respondents favouring a review of the Act increased from 71% to 85%. The Society of Psychiatrists of South Africa conducted a similar survey of its members and found that 51% of psychiatrists supported termination on request before the 12th week of pregnancy, while an equal number felt that the role of psychiatrists in the implementation of the Act should be reduced, and 89% called for the present legislation to be reviewed (Nash, Brink, Potocnik & Dirks, 1992). Thus, most of the significant professionals involved in the current implementation of therapeutic abortions in South Africa request a review of the present Act.

Most political groupings and parties have avoided the issue of abortion law reform, presumably for fear of alienating potential voters (Chubb, 1993; Makatini, 1993). According to Chubb (1993), even women's organisations have been reluctant to engage in this sensitive debate and to assume public positions on the issue of freedom of choice. There has, however, been a shift in the 1990s, with women's rights receiving more attention within a human rights perspective. Historically, the human rights position emerged when women began to assert their rights as equal partners. This position supports the right to reproductive choice and reproductive health care (Rahman & Pine, 1995). Makatini (1993) argued that South African society has to move beyond the traditional arguments of whether life begins at conception or not, and to address the question of abortion at a human rights level. Enshrined in a Bill of Rights as a human right, access to abortion will apply universally to all women in a non-discriminatory manner, and the views of all women would be represented as they would be able to make their own individual choices (Makatini, 1993). Within this context, women's right to choose has become an issue within the constitutional debates (Dyer, 1995). In tandem with the position that all discriminatory legislation be identified and removed in order to protect and advance women's

rights, there has been a call for research to be conducted to look at the impact of such legislation on women (Beijing Conference Report, 1995).

The World Health Organisation (WHO) recommended action to encourage governments to do everything possible to prevent and eliminate the severe health consequences of unsafe abortion (cited in Sweetman, 1994). They further reaffirmed that women should have access to high quality and affordable abortion services and counselling (Rahman & Pine, 1995). In 1994, the African National Congress (ANC) released its National Health Plan which promotes the liberalisation of abortion laws (St. Leger, 1994). In the draft proposals of the ANC's Reconstruction and Development Programme, women's reproductive rights are outlined as follows (Dyer, 1994, p. 1):

> Reproductive rights must be guaranteed and reproductive health services must promote people's right to privacy and dignity. Every woman must have the right to choose whether or not to have an early termination of pregnancy according to her own individual beliefs.

Shortly thereafter the Minister of Health gave notice of a motion to the National Assembly that a select committee was to be appointed 'to enquire into and report on possible amendments to the Abortion and Sterilisation Act' (Dyer, 1994, p. 2). In addition to abortion's claim to inclusion on the national agenda on grounds of women's health and maternal mortality, it was also seen as an issue of basic rights and women's empowerment. It was recently announced that the Select Committee on Abortion opted for a pro-choice position, recommending that the current Act be repealed to allow abortion on demand (Staff Reporters, 1995). The Select

Committee recommended that abortion be allowed on request up to the 24th week of pregnancy and that non-directive counselling should be made available to all women asking for an abortion (Geldenhuys, 1995, see Appendix C). While the pro-life movement is vehemently opposed to these recommendations (Newbury, 1995), those who support them believe that the recommendations reflected a humane, practical and reasoned approach to the issue of abortion (Staff Reporter, 1995). Pro-choice supporters believe that new legislation will enable women to participate more equally in society and give them more control over their bodies and lives (Geldenhuys, 1995). However, there is not yet clarity about how and when full reproductive rights will be entrenched. Sarkin-Hughes (1993) argued that, with new legislation, a full-service approach to women's physical *and psychological* well-being be implemented. To begin with, this would require an understanding of the psychological experience of abortion for women in South Africa, about which little is yet known. Recently there have been two exploratory investigations into the psychology of induced abortion in South Africa (McCulloch, 1996; Maforah, 1995). Generally, however, findings of women's post-abortion emotional responses have come from studies conducted in Europe and the United States. These will be reviewed in the following section.

2.3 Post-Abortion Emotional Responses

The literature on abortion outcome is voluminous. The psychological implications of induced abortion have been debated continuously over the last three decades. Predominantly, psychological research on abortion has been influenced by the historical trends of abortion legislation internationally. The early research was done at a time when abortion was illegal and

treated as a taboo subject. The research findings reflected the generally accepted belief that abortion was beyond the range of 'normal' experience.

The early literature, from 1935 to 1964, has been extensively reviewed by Simon and Senturia (cited in David, 1985). Many of the articles examined by these researchers focused on negative aspects and generally concluded that serious psychological problems followed abortion. The authors of the articles reviewed shared the perspective that abortion was a 'tremendous threat to the integrity of the ego structure' (Simon & Senturia, cited in Romans-Clarkson, 1989, p. 558). Kummer (cited in Adler, 1979), noted that the frequent reference in medical literature to post-abortion psychiatric illness was not based on statistical documentation. His review of literature from other countries and a survey of experiences of psychiatrists in the United States led him to conclude that this widely held belief was a myth resulting from the enforcement of a taboo against abortion.

There are many reasons for the conclusions reached in the early studies. Serious methodological problems in sample selection frequently occurred (Romans-Clarkson, 1989). For example, samples were often chosen from populations of women seeking therapy, and the negative affective states of these women were assumed to be representative of all women who had undergone abortion (Adler, 1979). Generalisations were often made from findings based on single case histories (David, 1985). In addition, differentiations were not made between women who had undergone legal or illegal abortions; or between women who had undergone first- or second-trimester abortions (David, 1973); or between women who had undergone single or repeated abortions (Russo & Zierk, 1992). In addition to methodological flaws, the conclusions drawn by researchers and writers were frequently influenced by the strong negative emotional

and social beliefs about abortion (Adler et al., 1990). Simon and Senturia (cited in Adler, 1979), in their review of early studies, concluded that 'deeply held personal convictions frequently seem to outweigh the importance of the data, especially when conclusions are drawn' (p. 103).

2.3.1 Normative Responses to Abortion

A dramatic shift in research conclusions regarding abortion occurred in the 1960s and 1970s. The tide of psychiatric opinion began to turn away from the expectation that abortion was invariably followed by deleterious psychological effects (Adler, 1979). A study done in Scandinavia by Ekblad (cited in Adler, 1979) is often considered a turning point. This was the first relatively well-controlled study of abortion. It revealed that a legal abortion produced feelings of guilt and self-reproach in many women but rarely were the psychological sequelae so severe as to be described as pathological.

Since then, numerous studies on the effects of abortion have been conducted in the United States and Europe. Most have been descriptive, attempting to document the frequency of different psychological reactions to abortion. The studies have almost unanimously concluded that induced abortion does not constitute a serious psychological trauma or precipitate prolonged emotional conflict for most women (e.g., Adler et al., 1992; Burnell & Norfleet, 1986; Osofsky & Osofsky, 1972; Peck & Marcus, 1966; Posavac & Miller, 1990; Rogers, Stoms & Phifer, 1989). Several studies show that the predominant response immediately following abortion is most often relief (Lazarus, 1985; Osofsky & Osofsky, 1972). Other research has shown improvement in mood and functioning from the pre- to the post-abortion state (e.g., Lazarus &

Stern, 1986; Major & Cozzarelli, 1992). Russo and Zierk (1992) speculated that the positive relationship of abortion to well-being appears to be due to abortion's important role in controlling fertility. However, negative effects have been observed as well. Some women report periods of depression, anxiety, guilt or regret following the procedure (Adler et al., 1990; Major, Mueller & Hildebrandt, 1985; Mueller & Major, 1989). Adler (1979) and Lemkau (1988) claimed that these are usually experienced to a mild degree and diminish over time. However, cases of longer term psychotic reactions have also been reported (e.g., Gibbons, cited in David, 1985). David (1985) cited a prospective study conducted during 1975-76 in the United Kingdom by Brewer (1977) which found three post-abortion psychoses per 1000 legal abortions.

Adler (1979) identified three separate factors to explain variations in emotions experienced by women after induced abortion. One factor represented *positive emotions* of happiness and relief. The negative emotions were represented by two separate factors. One, consisting of shame, guilt and fear of disapproval was termed *socially based*, and postulated to reflect social stigma and norm violations, dependent on the social context of the abortion process. The second negative emotion factor, consisting of regret, anxiety, depression, doubt and anger, was termed *internally based*. These emotions seemed to relate to the meaning of the pregnancy for the woman. In this study, women reported positive emotions to a much greater degree than either set of negative emotions two or three months post-abortion. However, mild levels of negative feelings often accompanied the positive ones. Adler's (1979) work offered a framework for considering the impact of multiple factors on emotional well-being after abortion. It emphasised that women's responses to abortion are not determined by only one variable or type of variable,

but that the way in which a woman responds to the abortion procedure will be a joint function of her psychological state and the social environment in which the abortion occurs.

2.3.2 Psychological Factors Related to Adjustment to Abortion

Several studies have gone beyond mere description to consider the characteristics associated with positive or negative responses to abortion. This research began to shed some light on the nature of abortion and the influence of social-psychological variables on responses to the procedure. Prominent in the literature are two recent reviews by Adler et al. (1992) and Major and Cozzarelli (1992), both of which examined psychosocial factors that may serve as 'risk factors' for the experience of negative emotional responses to induced abortion. These reviews considered only the better-designed studies of post-abortion adjustment, only studies conducted in the United States, and only studies that assessed responses to abortions obtained under non-restrictive, legal conditions (e.g., Major, Mueller & Hildebrandt, 1985; Mueller & Major, 1989; Russo, Horn & Schwartz, 1992). In contrast to previous reviews, the authors focused on factors that are related to, or predictive of, post-abortion adjustment (generally measured 30 minutes to three months post-abortion).

In summary, the reviews concluded that women who are most likely to report affective distress in the short-term post-abortion period include women who :

a) report that the abortion decision was highly difficult and/or that the pregnancy was intended (potentially reflecting personal conflict about the pregnancy and abortion);

b) blame the pregnancy on their own character or on another person;

c) have low expectancies regarding their ability to cope with stressful life events in general, or with the abortion in particular;

d) perceive little social support from their partner, friends and/or family.

In addition, several less-studied factors were also identified as being predictive of poorer post-abortion adjustment. These include :

a) perceived social conflict with, or opposition from significant others about the abortion;

b) the presence of a partner who himself is having difficulty coping with the abortion;

c) maladaptive coping styles;

d) a low level of psychological functioning prior to the discovery of the pregnancy;

e) certain life events (e.g. infertility, loss of a child) that occur subsequent to the abortion (Adler et al., 1992; Major & Cozzarelli, 1992).

These factors are potentially significant in predicting women's adjustment to abortion, and therefore warrant discussion.

2.3.2.1 The Decision Process

Existing research suggests that the abortion decision is complex; involving a wide variety of influences (Cohan & Dunkel-Schetter, 1993; Gameau, 1993; Stevans, Register & Sessions, 1992; Rogo, 1993). Although most women do not find the decision to abort difficult (Adler et al., 1990), some have moral concerns and value conflicts about their decision, and some describe the decision process as stressful and difficult (cited in Lazarus & Stern, 1986). Difficulty in making the decision may reflect the extent to which the abortion conflicts with the

woman's values and religion, the intentionality of the pregnancy and the extent to which others have influence over her decision (David, 1993; Major & Cozzarelli, 1992). Lemkau (1988) proposed that decisions about child-bearing are of such importance that ambivalence is the norm, and that the socio-cultural environment in which women make abortion decisions at best reinforces ambivalence. In addition to this indecision, increased difficulty with the abortion decision has been related to being married, the length of time that the woman has been pregnant, negative attitudes towards abortion, lack of perceived social support from significant others and lower levels of education (Adler et al., 1992; Lydon, 1993; Millner & Widerman, 1994; Stevans et al., 1992).

Studies that have examined the relationship between both aspects of satisfaction with the abortion decision, and post-abortion emotional responses, consistently demonstrate that women who are satisfied with their choice or report minimal difficulty in making the decision, show more positive post-abortion responses (Adler et al., 1992). Greater difficulty with the abortion decision has been related to poorer post-abortion adjustment, including feelings of guilt (Osofsky & Osofsky, 1972), internally based negative emotions (for example, regret, depression, anxiety and anger) and socially based negative emotions (for example, shame and fear of disapproval) (Adler, 1979).

Major and Cozzarelli (1992) hypothesised that one possible explanation for the relationship between decision difficulty and poorer post-abortion adjustment is that women who experience a difficult decision are those who intended the pregnancy or attach more meaning to the pregnancy. Women may choose to abort an intended pregnancy for several reasons, including social coercion or an unexpected change in the relationship with the partner. According to

Adler et al. (1992), women who abort intended pregnancies are most likely to respond negatively to abortion. Major et al. (1985) added that women who experience the pregnancy to be highly meaningful report significantly more negative consequences from the abortion. Although McCulloch's (1996) South African study did not differentiate between legal and illegal abortion, and between short-term and long-term post-abortion responses, her results confirmed these findings. McCulloch (1996) also established that supportive, non-judgemental pre-abortion counselling may be critical in decreasing decision difficulty, which in turn favours positive post-abortion adjustment.

2.3.2.2 Attributions for the Pregnancy

Attributions for negative life events have been found to relate to subsequent psychological adjustment (e.g., Michela & Wood, cited in Adler et al., 1992). In relation to abortion, adjustment may be influenced by the woman's attributions for the pregnancy. Major et al., (1985) and Major and Cozzarelli (1992) examined the extent to which women attributed their pregnancy to aspects of their own character, their own behaviour, chance, the situation they were in at the time or someone else. Women who blamed their pregnancy on their own character were significantly more depressed, anticipated more severe negative consequences from the abortion and tended to have more negative moods immediately post-abortion than did women who were not self-blamers.

Mueller and Major (1989) also conducted a study to explore the effect of a pre-abortion counselling intervention designed to reduce characterological blame for the pregnancy and shift attributions for undesired pregnancy to controllable factors (such as behaviours). As predicted,

the women in the study reported significantly better moods than women who were not exposed to the counselling intervention. This finding indicated that attributional style can influence individuals' adjustment to stressful life events.

2.3.2.3 Coping Expectancies

A third set of factors that has been examined as a predictor of adjustment to abortion is an individual's coping expectancies. Early research on coping has shown that both generalised positive outcome expectancies (Scheier & Carver, cited in Adler et al., 1992) and coping expectancies regarding specific situations (Bandura, cited in Adler et al., 1992) relate to better outcomes and successful treatment of psychological disorders. Coping expectancies also appear to play a role in post-abortion responses. Major et al. (1985) and Mueller and Major (1989) assessed women's pre-abortion coping expectancies, and found that women who expected to cope well were less depressed, had more positive moods and anticipated fewer negative consequences in the short term following abortion, compared to women who expected to cope less well.

Belief in one's ability to cope has been found to be causally linked to post-abortion emotional responses. Mueller and Major (1989) examined the effects of a pre-abortion counselling intervention on post-abortion adjustment. The intervention was directed at raising women's expectations that they could cope successfully with their abortion. They found that enhancing self-efficacy for coping was effective in lowering women's risk for depressive symptoms after abortion. Thus, these studies have shown that both generalised coping expectancies and event-

specific coping expectancies are influential predictors of women's short-term adjustment to abortion.

2.3.2.4 Perceived Social Support

Major and Cozzarelli (1992) confirmed that the most frequently examined psycho-social predictor of adjustment to abortion has been perceived social support. Research within the general stress and coping literature has established that a connection exists between social support and general well-being (Ensel & Lin, 1991). According to Cohen and Wills (cited in Adler et al., 1990), both perceived and actual social support can buffer some adverse psychological effects of stressful life events. Studies that have examined the relationship between perceived social support and women's adjustment to abortion suggest that perceived support from significant others (partner and parents) is associated with more positive post-abortion responses (e.g., Congleton & Calhoun, 1993; Robbins & DeLamater, cited in Adler et al., 1992; Romans-Clarkson, 1989; Zolese & Blacker, 1992).

Major, Cozzarelli, Sciacchitano, Cooper, Testa and Mueller (1990) explored the factors that mediate the propitious effects of perceived social support. They found that perceived social support enhanced adjustment indirectly through its effects on self-efficacy. According to Bandura (cited in Major et al., 1990), self-efficacy concerns self-percepts or judgements about how effectively one can perform necessary actions in specific situations. Women who perceived high support from their family, friends and partners had higher self-efficacy for coping. Higher self-efficacy, in turn, predicted better adjustment with regard to post-abortion emotional responses. High feelings of self-efficacy were related to lower depression, better mood and

fewer anticipated negative consequences post-abortion. Importantly, perceived support had no direct influence on adjustment, but functioned exclusively through increasing perceived coping self-efficacy (Major et al., 1990).

In summary, perceived support appears to be related to more positive post-abortion adjustment. However, the relationship of social support to post-abortion emotional responses may be mediated and governed by other variables.

2.3.2.5 Social Conflict

Recent research has suggested that the influence of social interactions that are perceived as negative or non-supportive may be as important as supportive interactions in determining adjustment (e.g., Coyne & DeLongis, cited in Major & Cozzarelli, 1992). Negative or non-supportive relations have been defined as ones that (a) do not meet desired or expected levels of support, (b) present negative responses (Fiore, Becker & Coppel, cited in Major & Cozzareli, 1992), (c) are perceived as sources of problems (Rook, cited in Major et al., 1990) or (d) are upsetting (Sandler & Barrera, cited in Major et al., 1990).

The few studies that have examined this issue point to the deleterious effects of non-supportive transactions or negative social ties on adjustment to stressful life events. Furthermore, these studies suggested that the presence of negative or non-supportive interactions is more predictive of poor short-term adjustment than is the absence of positive, supportive interactions (Major et al., 1990); an effect that La Rocco, House and French (cited in Major et al., 1990) have termed 'negative buffering'. This finding is particularly significant in the case of abortion since many

women do experience conflict, opposition and negative responses from others about their decision to abort.

2.3.2.6 Relationship with the Male Partner

As the findings on perceived social support illustrate, the role of the male partner is a potentially significant factor in women's post-abortion adjustment. Surprisingly, however, the male partner's responses to the abortion experience and the impact of the male partner's experience on women's adjustment have only been marginally dealt with by researchers. To address this under-explored area, recent research has focused on the dynamics of the relationship between couples seeking abortion, and has concluded that certain relationship patterns have noticeable effects on women's adjustment to abortion (Barnett, Freudenberg & Willie, 1992; Black, 1991; Cozzarelli, Karrasch, Sumer & Major, 1994; Major, Cozzarelli, Testa & Mueller, 1992; Major et al., 1985).

The few studies that have attempted to explore the role of a woman's partner in the abortion process have demonstrated that the issue is complex. Following the reasoning that one tangible form of social support that a man might offer his partner is to accompany her to the abortion procedure, Major et al. (1985) hypothesised that accompanied women would exhibit better post-abortion adjustment than women who were not accompanied. Instead, they found that these women were significantly more depressed in the short term than those who were not accompanied. These women were also significantly younger and had lower coping expectancies than women who were not accompanied. Major and Cozzarelli (1992) speculated that although accompaniment by the partner seems by definition to indicate social support, his accompaniment

may be a result of the woman's prior distress rather than an independent factor that would predict better post-abortion adjustment.

Major et al. (1992) examined the impact of men's attributions for pregnancy and expectations for coping with abortion on their partner's post-abortion adjustment. It was found that male partners' coping expectancies affected women's adjustment only if the women themselves had low coping expectancies. Among women with low coping expectancies, those accompanied by partners who also had low coping expectancies were the most depressed. Black (1991) also found that partners significantly influence each other's responses through their own coping efforts and that poor coping attempts by the male partner signals an area of vulnerability for the woman's post-abortion adjustment. These findings suggest that the mere presence of a significant other is not enough to secure positive adjustment in women undergoing abortion.

Cozzarelli et al. (1994) examined the impact of relationship dynamics on women's adjustment to abortion more closely. Firstly, they investigated the relationships between accompaniment/non-accompaniment by the male partner and (a) a woman's personal coping resources prior to the abortion, (b) the extent to which the woman perceived her partner as supportive, and (c) the level of commitment she perceived present in her relationship with her male partner. Secondly, the relationship between accompaniment and post-abortion distress was re-examined. The effects of accompaniment on women's post-abortion distress were found to be neither universally positive nor universally negative, but were more beneficial for women high in personal coping resources (e.g., self-esteem) than for women low in these resources. The results of this study imply that clinical interventions that encourage women undergoing

abortion to take their partners with them to the abortion procedure, should not be applied without reference to the specific characteristics of the woman involved (Cozzarelli et al., 1994).

2.3.2.7 Coping Styles

Major and Cozzarelli (1992) concluded that women's post-abortion adjustment may also be affected by the specific coping styles they employ to deal with the experience. Since a comprehensive discussion of coping theory follows later in the chapter, it will suffice to merely highlight here that coping involves a wide range of cognitive and behavioural strategies that have both problem-solving and emotion-regulating functions (Adler et al., 1992). Therefore, coping is assessed with reference to specific strategies that are used in a particular situation that is experienced as stressful.

Only one study has assessed the relationship between coping styles and short-term adjustment to abortion. Cohen and Roth (cited in Major & Cozzarelli, 1992) established that women who showed high levels of avoidance or denial prior to the abortion displayed more anxiety and depression immediately post-abortion than those who had shown low levels of denial. Women who employed, what they termed, an active approach coping style (e.g., thinking about, talking about) before the abortion showed a decrease in anxiety from pre-abortion to immediately post-abortion, whereas those who were low in active approach coping styles did not.

Although not a direct investigation of the relationship between coping strategies and post-abortion adjustment, a recent study by Cozzarelli (1993) assessed women's personal resources that function as stress resistance aids. She suggested that dispositional factors such as high self-

esteem, perceived control and optimism were related to increased feelings of self-efficacy for coping with abortion. Several authors have also suggested that these dispositional factors may operate as stress resistance aids by fostering positive beliefs about an individual's ability to successfully manage a stressful experience or, more specifically, by increasing feelings of self-efficacy (e.g., Lazarus & Folkman, cited in Cozzarelli, 1993). This, in turn, is related to better short-term post-abortion adjustment. Whilst there is no research to support this idea, it is suggested that these, and perhaps other, personality factors may lend themselves to more functional coping strategies. However, it is clear that the implications of specific coping interventions for adjustment to abortion merit further attention.

2.3.2.8 Level of Psychological Functioning Prior to the Pregnancy

Another factor that appears to be receiving increasing attention recently is a woman's general level of psychological functioning prior to her pregnancy. It has been hypothesised that this factor may be critically important in predicting women's adjustment to the abortion experience (e.g., Dagg, 1991; Gameau, 1993; Lemkau, 1988; Romans-Clarkson, 1989; Russo & Zierk, 1992). One indicator of a woman's general level of psychological functioning may be her chronic ability or inability to deal with stress. In general, a woman who has high coping expectancies, a relatively internal locus of control and a high level of ego resiliency may be more likely to feel that she can deal with an abortion (Dagg, 1991; Major & Cozzarelli, 1992).

Although all of the research reviewed by Major and Cozzarelli (1992) sampled women after they had discovered their pregnancy and decided to abort it, it is highly probable that women who display poorer psychological functioning in general will also display poorer psychological

functioning subsequent to an abortion. Major and Cozzarelli (1992) hypothesised that psychological maladjustment occurring subsequent to an abortion is often misattributed to the abortion experience, whereas it may be more reflective of adjustment problems present prior to the pregnancy.

It has been proposed that women with pre-existing emotional problems are at higher risk for negative post-abortion emotional responses than are other women (Bagarozzi, 1994; Ney, Fung, Wickett & Beaman-Dodd, 1994; Russo & Zierk, 1992; Speckard & Rue, 1992; Zolese & Blacker, 1992). Dagg (1991) reported that women who experienced the most distress after an abortion were more likely to have lower self-esteem and a higher sense of alienation. Bagarozzi (1994) found that women who used denial and repression in dealing with emotional difficulties experienced before the abortion, generally managed the stress of their pregnancy and subsequent abortion poorly, and reported significant post-abortion distress.

Some researchers have maintained that these women may be at risk for suffering immediate, chronic, long-term, delayed and/or acute post-abortion grief reactions (McAll & Wilson, 1987; Ney et al., 1994; Speckard & Rue, 1992, 1993). Speckard and Rue (1993) defined this response as Post Abortion Syndrome (PAS), a specific type of Post Traumatic Stress Disorder caused by a traumatically experienced abortion. They specified that in cases of PAS the trauma of how the 'fetal child died' (p. 29) is re-experienced in flashbacks, nightmares, panic reactions and intrusive thoughts. According to Speckard and Rue (1993), these women exhibit high degrees of boundary ambiguity with respect to the aborted fetus and maintain an ongoing, high level of attachment to the fetus despite its loss, resulting in impacted grief. Russo and Zierk (1992) caution that labelling a woman's post-abortion feelings as PAS within the context of

normative responses to abortion may function more in the service of political advocacy than in the service of assisting a woman to work through her post-abortion feelings.

2.3.2.9 Events Subsequent to the Abortion

A final set of factors that may influence adjustment to abortion over time is events that occur subsequent to the abortion (Congleton & Calhoun, 1993; Major & Cozzarelli, 1992). It is important to recognise that people continually reconstruct and reinterpret past events in the light of subsequent experiences. Under stressful and tragic circumstances, ideas of punishment and retribution surface, even among individuals who do not consider themselves especially religious (Russo & Zierk, 1992). Lemkau (1988) pointed out that under stressful conditions such as infertility, the subsequent loss of a child or catastrophic illness, which are all associated with depressed mood and cognitive distortions, it is possible for a woman to make highly idiosyncratic causal connections to an earlier abortion as well as to other events in her life; for example, infertility in the present may be attributed to an abortion in the past. However, these issues have received no attention in the empirical literature on post-abortion adjustment (Major and Cozzarelli, 1992).

2.3.2.10 Summary

Of these psycho-social factors, Major and Cozzarelli (1992) postulated that a woman's coping expectancies are the most proximal and important predictor of short-term post-abortion adjustment. They proposed that many of the above factors may exert their beneficial or

detrimental effects on adjustment by enhancing or undermining feelings of self-efficacy for coping with abortion.

Coping self-efficacy was found to be enhanced by the following:

(1) perceived positive support from significant others;

(2) attributions of the pregnancy to controllable or non-stable factors such as behaviours and situations;

(3) generalised positive expectancies in relation to one's ability to cope with stressful life events in general;

(4) having a partner who himself expects to cope well with the abortion;

(5) being older, and thus probably being more mature and having more financial and other tangible resources;

(6) experiencing fewer moral conflicts about the abortion decision (Adler et al., 1992; Major & Cozzarelli, 1992).

In contrast, coping self-efficacy was found to be undermined by the following:

(1) perceiving significant others as non-supportive or oppositional to the abortion decision;

(2) attributing the pregnancy to stable and relatively uncontrollable factors such as one's character or another person;

(3) negative coping expectancies;

(4) a partner who does not expect to cope well with the abortion;

(5) younger age and correspondingly fewer resources;

(6) a difficult and ambivalent abortion decision (Adler et al., 1992; Major & Cozzarelli, 1992).

2.3.3 Theoretical Frameworks

Contemporary research on abortion is considered from the perspective of stress and coping, one of two broad theoretical frameworks underlying abortion research (Adler et al., 1992). Much of the research on abortion has been descriptive rather than theory-based. Earlier work on abortion, deriving from clinical experience and theories, focused on psychopathological responses following abortion. This perspective draws heavily on psychoanalytic theory. From the perspective characterising more recent work, abortion is seen as a potentially stressful life event that poses challenges and difficulties to the individual but does not necessarily lead to psychopathological outcomes (Adler et al., 1992). Rather, a range of possible responses, including growth and maturation, as well as negative affect and psychopathology, can occur.

Differences in these perspectives have influenced the kinds of questions asked and methodologies used to study women who have had abortions. Adler et al. (1992) stated that clinical case studies drawn from the experience of clinicians or those studying women who are self-selected because they have reported psychological distress following an abortion (e.g., Speckard & Rue, 1992) have looked almost exclusively at indicators of psychological distress. According to Adler et al. (1992) broader descriptive studies and research conducted from a stress and coping perspective have generally used more representative samples of women undergoing abortion, strengthening the generalisability of findings. In addition, some studies have investigated both

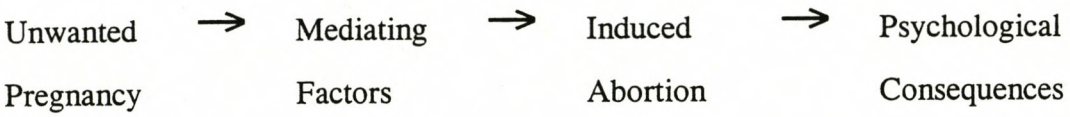
positive and negative outcomes, providing a fuller picture of the experiences of women undergoing induced abortion (Major & Cozzarelli, 1992).

In a review of empirical studies reported in the research literature, Miller (1992) confirmed the predominant use of these two broad theoretical frameworks to interpret research findings. However, he also found evidence of other, although lesser used, theoretical models, either explicitly or implicitly contained in the literature. Although these models are not specifically located within either of the two dominant theoretical frameworks, most of them reveal a bias towards the stress and coping model and therefore merit attention. All the models presented are variations of the *basic model*, shown in Figure 2.1, in which an unwanted pregnancy leads to some intermediate factor and to an induced abortion, which in turn leads to some psychological consequences. Miller (1992) warned that this is obviously a great simplification, but that it suffices to represent the core components of most models.

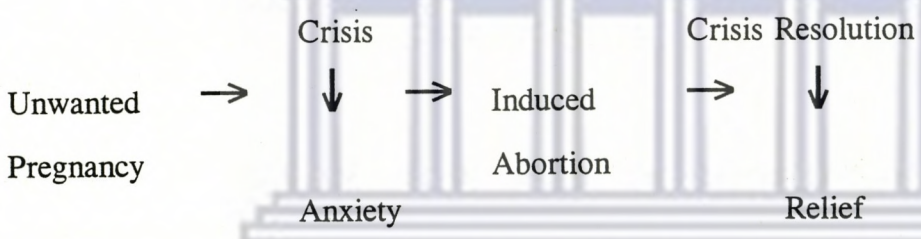
There are two models that tend to emphasise the psychological consequences which immediately follow abortion. One is the *crisis model* shown in the middle of Figure 2.1. This model is supported, for example, by some of the research findings reported by Osofsky and Osofsky (1972), Adler (1979) and Lazarus (1985), which show that relief and reduction of anxiety are among the primary affects experienced following abortion. Adler (1979) argued that as with other crises, it holds the potential for psychological maturation for women who master the experience successfully. The other model is the *biological model*, which is schematised at the bottom of Figure 2.1. In this model the interruption of pregnancy leads to an abrupt reduction of certain circulating hormones, which temporarily alters the woman's state of mind. This type

of model, unrelated to the stress and coping paradigm, is implied in some discussions in the literature (Lemkau, 1988) and may play a role in what has been called the 'post-abortion blues'.

BASIC MODEL



CRISIS MODEL



BIOLOGICAL MODEL

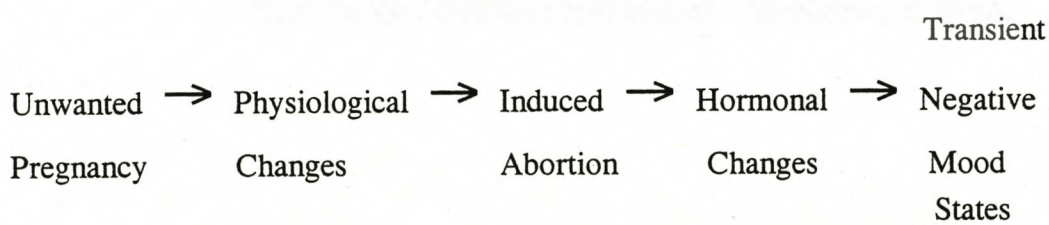


Figure 2.1. Three theoretical models of the psychological consequences of abortion (Miller, 1992).

Miller (1992) also described four models that address the possible short- to long-term psychological consequences. The first is the *norm violation model*, which is depicted at the top of Figure 2.2. This model is based on the assumption that social norms, which are generally pro-natal and anti-abortion, produce in the woman with an unwanted pregnancy, both conflict about having the abortion and guilt, shame and fear of disapproval if she goes through with it. These norms exist in the community and tend to be internalised by individuals. This model is contained in some of the research by Adler (1979) and the literature review of Illsley and Hall (cited in Miller, 1992).

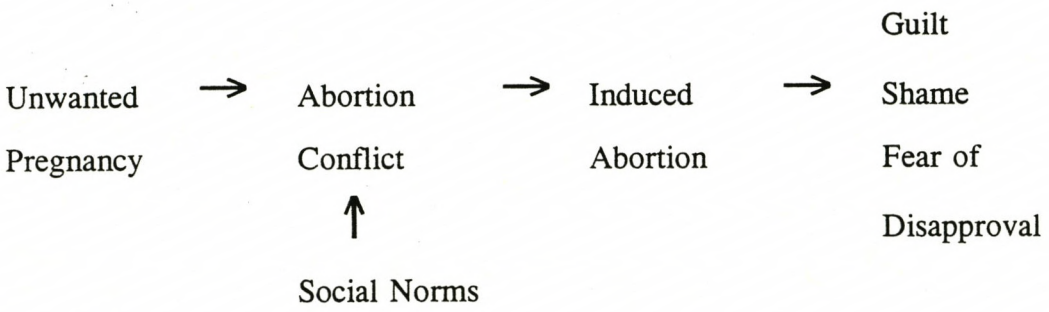
The second model described by Miller (1992) is the *loss model*, contained in the research of some investigators (e.g., Adler, 1979; Ney et al., 1994). The essential idea here is that women with an unwanted pregnancy experience different degrees of longing to bear the child. When this longing is adequately strong, women experience ambivalence prior to the abortion and a sense of loss, associated with grief, anger and depression after the abortion. This theme is also present when there is some form of coercion related to obtaining an abortion. In this situation, the pregnancy is basically wanted but certain external influences, such as strong pressure from parents or partner, make the abortion 'necessary'. As a result, the woman's underlying child-bearing desire leads to pre-abortion ambivalence and a post-abortion feeling of loss.

Miller (1992) presented the *decision model* as being implicit in the work of many researchers. This model emphasises the decision-making process prior to the abortion and the negative feelings about the decision that follow. It features prominently in studies by Shusterman and Cohen and Roth (cited in Miller, 1992). This model firstly emphasises how situational constraints, such as conflict with the partner, interferes with the effectiveness of the decision-

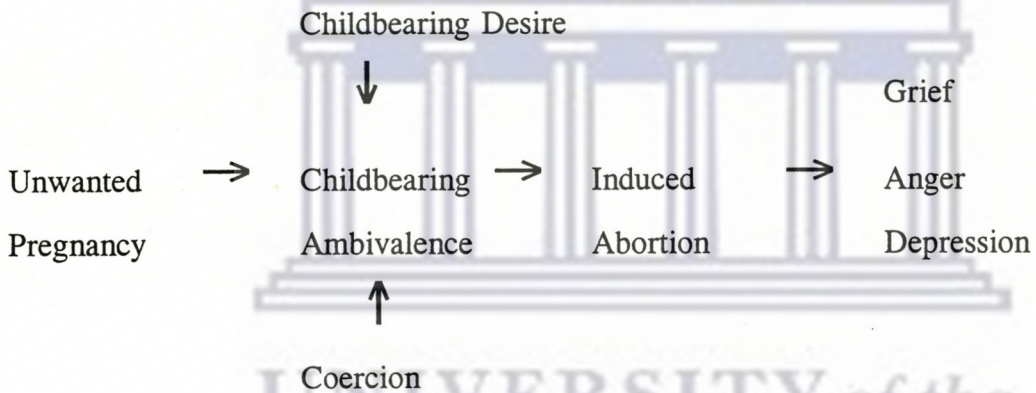
making process. Secondly, it emphasises that unforseen developments after the abortion, such as difficulty in conceiving, may lead to regret and self-condemnation despite the scrupulousness of the original decision-making process.

The final model that Miller (1992) considered is the *learning model*, schematised at the bottom of Figure 2.2. The central notion here is that women learn and change their behaviour as a result of the unwanted pregnancy and induced abortion experience. These changes may be positive, such as responsible contraceptive use, or negative, such as fear of sex. Osofsky, Osofsky and Rajan (cited in Miller, 1992) suggested that these changes may be attributed to the negative affects, especially anxiety, that are present during the experience, as well as to the insights and self-awareness that the woman may achieve while attempting to resolve the problem.

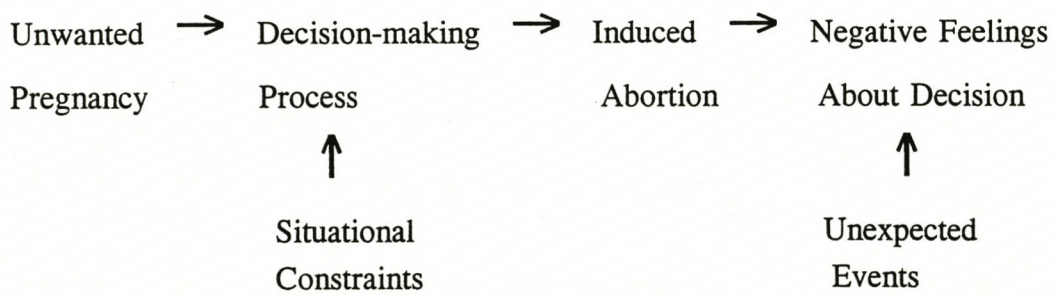
NORM VIOLATION MODEL



LOSS MODEL



DECISION MODEL



LEARNING MODEL

Unwanted Pregnancy	→	Anxiety/ Insight	→	Induced Abortion	→	Behaviour Change Relationship Change

Figure 2.2. Four additional theoretical models of the psychological consequences of abortion (Miller, 1992).

Outside of Miller's (1992) review, but in keeping with psychoanalytic considerations of the psychological consequences of abortion, Erikson (1993) advanced a *conflict model* of trauma to account for the nature of abortion as a traumatic stressor for some women. According to Erikson (1993), the existence of the fetal child in utero requires an adaptation in the mother's internal psychological world, involving the construction of a representation of an attachment object. Erikson (1993, p. 40) stated that:

> Destruction of the fetal child assaults the stability of the corresponding internal structure; the conflict between life and death is then played out internally, with all the accompanying anguish of post-traumatic stress disorder symptoms.

His proposition that this conflict is at the centre of the traumatic experience is based on clinical case material, so that this model cannot be applied to the majority of women who do not present with psychopathological outcomes to abortion (Adler et al., 1992).

Finally, it was considered that of the theoretical models that were reviewed, the *stress and coping model* was the most relevant one within which to locate the present study. Over the past two decades, psychologists have devoted increasing attention to the ways in which people cope with stressful life events and to factors that predict and enhance coping with such events (Cozzarelli, 1993). Many investigators have used this model in exploring such risk factors as coping style, previous mental illness and social support at the time of the abortion as being important determinants of post-abortion adjustment (Adler et al., 1992). The psycho-social factors that were investigated in the present study were considered within the broader theoretical context of coping with stressful life events in general (Lazarus & Launier, cited in Major & Cozzarelli, 1992). Research on the effect of stressful life events has pointed to the importance of personal (for example, self-esteem) and situational (for example, social support) variables that mediate or moderate the impact of such events on the individual (Adler et al., 1992; Cozzarelli, 1993). Lazarus (1993) advanced a strong empirical case for the hypothesis that stress and coping processes are influenced by variables in the environment and within the person. This theoretical position is seen to be compatible with the chosen method of investigation for the present study, that is, the qualitative research method; to be discussed in the following chapter. Thus, research conducted from a stress and coping perspective was considered appropriate to exploring both positive and negative outcomes, providing a fuller picture of the experiences of women undergoing induced abortion.

From the stress and coping perspective, stress is defined as arising from an interaction of the individual and the environment in situations that the person appraises as 'taxing or exceeding his or her resources and endangering his or her well-being' (Lazarus & Folkman, cited in Adler et al., 1992, p. 1197). Stress and coping theory focuses on life stressors and psycho-social

resources as its two key concepts (Lazarus, 1993; Lazarus & Folkman, cited in Seiffge-Krenke, 1993). Within this framework, coping is defined as 'problem-solving efforts made by an individual when the demands he/she faces are highly relevant and tax his/her adaptive resources' (Lazarus, Averill & Opton, cited in Seiffge-Krenke, 1993, p. 227). In this conceptualisation, coping is seen as a process rather than an enduring trait or style of the individual. This definition emphasises efforts of coping independent of outcome. Lazarus (1993) referred to two major functions of coping, either directed at regulating emotional responses or directed at altering the problem which causes the distress. Research on abortion has focused on the inter-play between these two functions.

Effective adjustment depends on how a woman copes with the stress of the abortion. Lazarus (1976) suggested that there are two important ways of thinking about adjustment. The first has to do with its adequacy. As such, adjustment is regarded as an achievement that is accomplished either well or badly. This perspective allows the exploration of such questions as how unsatisfactory adjustment can be prevented and how it can be improved. The present study illuminated these questions to the extent that it explored implications for abortion counselling. The second perspective is adjustment as a process; it examines how an individual adjusts under different circumstances and what influences this adjustment. This was the primary focus of investigation of the present study. However, although these perspectives on adjustment are different, they also overlap, since only through understanding the processes through which women adjust to abortion, can women be helped to deal with or prevent adjustive failures.

2.3.4 Summary

Researchers warn that given the variety and complexity of the abortion experience, it is inappropriate to generalise from one abortion circumstance to another. There has been minimal research on the differences in response to abortion under legal and illegal circumstances, probably due in large part to the difficulty in obtaining comparable samples of women undergoing illegal versus legal abortions. Adler et al. (1992) hypothesised that the experience of illegal abortion is likely to be more stressful than that of a legal abortion. However, no evidence exists to show that emotional risks vary in accordance with the legislative restrictions on abortion (Ney & Wickett, 1989). Accordingly, a study that begins to explore 'risk factors' associated with induced, or illegal, abortion and their influence on short-term post-abortion adjustment may significantly contribute to the research base in the area. A further strength of the present study is the focus on black women in South Africa; a group that has been neglected by social science researchers.

Furthermore, in reviewing the literature on abortion, methodological shortcomings must be noted. Wilmoth (1992) warned that our current knowledge about the consequences of abortion rests upon conceptualisations, theories and methodologies that are frequently limited and flawed. Of all the potential complications of abortion, psychological responses are the most difficult to assess (David, 1994). One must recognise how difficult it is to conduct research on an experience with deep personal meaning which occurs in a context of moral controversy. Given these considerations, it has been suggested that abortion research needs to redefine its orientation and regard non-traditional methods of social science investigation as more suited to certain types of research questions (Wilmoth, 1992). With respect to the present study, it is suggested that

quantitative research is unsuited to capturing the fullness of women's abortion experiences. It is also of concern that the quantitative approach is inclined to objectify human experience and strengthen participants' feelings of alienation and disempowerment. The present study, then, was considered to be best located within a qualitative research framework. A detailed argument for the choice of a qualitative approach will be presented in Chapter Three.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

It was noted in Chapter Two that the present study was guided by recent shifts in the conceptualisation of abortion research. Since a significantly large body of research has concluded that induced abortion does not constitute serious psychological trauma for most women (Adler et al., 1992), contemporary researchers have found it more meaningful to investigate the factors influencing post-abortion adjustment (Major & Cozzarelli, 1992). These shifts have challenged traditional quantitative methods of conducting abortion research (Wilmoth, 1992). In response to both the challenge to consider methodology best suited to social science research, as well as to the exploratory nature of the present study, the qualitative research paradigm was considered to be the most responsive to the research question.

This chapter explores the limitations of quantitative research and provides a rationale for the choice of the qualitative model. It also describes the aims, sample, data gathering medium, data gathering procedures and data analysis strategies used in the study. Finally, it offers a statement of ethical considerations.

3.2 Assumptions and Rationale for a Qualitative Approach

Qualitative research designs have become increasingly important modes of inquiry for the social sciences. This development has been a direct response to the discussion of 'the theoretical basis' of research and what it is 'meaningful' to measure, which has been central to the debate about different research methodologies. This polemic has concerned itself with the two distinguishing schools of social science; the traditional, empiricist or positivist school and the constructivist, interpretive or anti-positivist school (Creswell, 1994).

Historically, there has been a heavy emphasis on quantification in science, that is, on the quantitative paradigm. In recent years, however, strong counter-pressures against mere quantification have emerged. The criticisms that have been mounted against positivism have warranted a serious consideration of the utility of the qualitative approach. A brief review of these critiques will be offered before examining the principles underlying qualitative research.

Quantitative approaches have been criticised for 'context stripping', that is, testing correlations between variables at the expense of other variables that exist in the context that might, if examined, greatly alter findings (Guba & Lincoln, 1994). The above criticism is concerned with the assumption that the observable actions and measurable indicators of social human behaviour are the objects of social research (Mouton, 1988). This has the effect of excluding meaning and purpose from the research context. It has been emphasised that human behaviour cannot be understood without reference to the meanings and purposes attached by human actors to their activities (Mouton, 1988; Silverman, 1993). Qualitative data, it is argued, provides both contextual information as well as rich insight into human behaviour.

Furthermore, in quantitative research, the emphasis is on interpreting social behaviour through knowledge of universally valid causes (Mouton, 1988). This assumption, then, is that it is possible to explain, predict and manipulate future social behaviour (Guba & Lincoln, 1994). The applicability of this cause-and-effect model to social behaviour has been challenged. Proponents of qualitative research have argued that human behaviour cannot be explained through a deductive form of logic with its accompanying intent on developing generalisations (Creswell, 1994; Silverman, 1993). Instead, the objective is to understand and interpret the meanings and motives that inform everyday human action (Mouton, 1988). Walsh (cited in Mouton, 1988, p. 4) concluded that:

> The particular problems of social behaviourism may be laid at the door of its reductionist conceptual framework which translates meaningful social activity into an object-world of overt behaviour.

He pointed out that, in quantitative research, actors' social meanings are converted into variables themselves, and are thus taken for granted in the analysis. This process has undermined socially and experientially based realities of individual persons and groups. It has resulted in the quantification, and sometimes dehumanisation, of individuals' experiences.

Finally, the positivist paradigm has been compromised by its insistence on reality being 'objective' and independent of the researcher (Creswell, 1994). In his examination of the philosophical debate on the nature of social science research, Mouton (1988) located the scientific idea of 'objective' research as central to the positivist model. This concept has advanced neutral and distanced research. It has been suggested that the notion that human

interaction is not influenced by individual actors and their respective worldviews, is both naive and problematic (Mouton & Marais, 1990). The principle of 'objectivity' has implications, too, for the issue of the role of values in research. The quantitative approach promotes value-free research. Critics of this posture have contended that all research is value-laden; it is a consequence of the fact that the creation of knowledge occurs within the dynamic and interactive context of the researcher-participant dyad (Hamilton, 1994). Like many recent reviewers of social science research, Habermas (cited in Hamilton, 1994, p. 67) pointed to the 'objectivist illusion' of social science research, and espoused, instead, the stance that there are indissoluble connections between knowledge, methodology and human interests. As a representative of dialectic thought, he suggested a paradigm of mutual understanding and interaction.

The above critique is representative of recent thinking which rejects the model of the natural sciences as being relevant for research in the social sciences (Mouton, 1988). Whilst it is not the intention of the author to define the positivist and the anti-positivist schools as polar opposites, and therefore undermine the use of quantitative methodology, it is suggested that the present study is best located within a qualitative paradigm. An elaboration of the qualitative approach will follow below.

A generic definition of qualitative research offered by Denzin and Lincoln (1994, p. 2) states that 'qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter'.

The above definition stresses that qualitative researchers study things in their natural settings, attempting to understand phenomena in terms of the meanings and definitions that individuals

attribute to them. Firstly, this principle acknowledges that human behaviour is significantly influenced by the context in which it occurs. Secondly, it emphasises the socially constructed nature of reality.

According to Gergen (1985), social constructionist inquiry is mainly concerned with explaining the processes by which people come to describe, explain, or otherwise account for the world in which they live, as well as themselves. Constructivist epistemology, therefore, emphasises the active participation of personal and social processes in the construction of reality (Hoshmand, 1993). Following on this, qualitative researchers recognise that human beings have interpreted social reality in their own manner, and that these everyday explanations of social reality give rise to the very social interaction that social scientists attempt to investigate. Qualitative inquiry is therefore built on the assumption that social theorising is essentially a re-interpretation of social reality by social scientists, after ordinary people have first interpreted their own social reality.

Accordingly, qualitative research involves the use and collection of a variety of materials, such as, case study, personal experience, interview, observational, interactional and life story texts, to understand and describe experiences and meanings in individuals' lives (Denzin & Lincoln, 1994). Data collected in this manner offer qualitative (rich, context bound) descriptions of the social world rather than quantified (observable, measurable) descriptions (Strauss & Corbin, 1990).

Additionally, in qualitative methodology, inductive logic prevails (Creswell, 1994). The emphasis is on generating contextually relevant descriptions of human behaviour, rather than on

the construction of universal laws of social behaviour (Mouton, 1988). The reluctance to generalise attributes of the social world affirms 'the interplay between a socially constituted self and a socially constituted environment' (Mouton, 1988, p. 6).

The assumptions reviewed above imply that qualitative research is a process. According to Denzin and Lincoln (1994, p. 11), this connotes that:

> The gendered, multiculturally situated researcher approaches the world with a set of ideas (theory, ontology) that specifies a set of questions (epistemology) that are then examined (methodology, analysis) in specific ways.

The above explanation also signifies the critical role of the researcher in qualitative inquiry. As a result, the notion of 'objectivity' is dismissed by qualitative researchers. Instead, the qualitative investigator admits the value-laden nature of the study and integrates his or her values and biases into the study, as well as recognises the value nature of information gathered from the field (Creswell, 1994). Qualitative research, therefore, attends to the researcher's own self-reflective awareness of his or her own constructions. This clearly demands a high degree of reflexivity from the qualitative researcher. According to Olesen (1994), a reflexive stance is a resource to guide data gathering and for understanding one's own interpretations and behaviour in the research. Qualitative researchers have argued that sufficient reflexivity serves to uncover what may be deep-seated but poorly recognised views on issues central to the research (Bannister, 1994).

However, it is to be noted that the above assumptions that underlie qualitative research have been challenged by critics. For example, qualitative researchers have been called journalists and their work termed unscientific, or only exploratory, or full of bias and a-theoretical (Denzin & Lincoln, 1994). These criticisms have been viewed mostly as reflective of the politics and tensions embedded in the field of research, and not substantial enough to disqualify qualitative research from the arena of social science research (Guba & Lincoln, 1994). According to Mouton and Marais (1990), redefining research as any analysis which reflects social reality, will create space for such research to be validated and realised through the qualitative approach.

Based on the foregoing discussion, then, the quantitative approach appears to be generally unsuitable for the present study. Instead, the qualitative research approach, which acknowledges the meaning of social reality for social actors and contextualises that meaning, emerges as the more suitable mode of inquiry for the present study. It is suggested that the qualitative approach is more appropriate in uncovering the depth and complexity implied by the question under investigation. With specific reference to abortion research, a methodological critique of quantitative inquiry will be offered below. The critique that is advanced is based on studies that have been reviewed in Chapter Two; most of which have been conducted within a positivistic paradigm. In presenting the limitations of the quantitative model in abortion research, it is hoped that the suitability of the qualitative paradigm, in responding to the aims of the present study, is adequately demonstrated.

In abortion research, diverse interpretations of findings are partially due to the limitations of the research methods used and partially a result of value judgements. While value biases are present in most areas of research, they appear to have been particularly problematic in the early

abortion research. Some biases have arisen from ideological perspectives or assumptions inherent in particular theories and approaches. However, the influence of these ideological perspectives on the interpretation of individuals' realities has not been acknowledged; instead this subjectivity has been advanced as 'scientifically objective' research. Further, the bias towards expecting severe negative responses inherent in a number of studies has been exacerbated by the inappropriate generalisation of conclusions from clinical or case studies that reveal little about the experience of the vast majority of women (Adler et al., 1992).

Several criticisms have been levelled at the use of various quantitative methods in the study of abortion. The limited operationalisation of post-abortion responses has been problematic in many studies (Adler et al., 1992; Ney & Wickett, 1989). A narrow set of research questions has been emphasised, focusing almost exclusively on pathological or negative outcomes. Adler et al. (1992) expressed concern that some researchers have used interviews to assess the mental health of abortion patients, but have not considered issues of accuracy, inter-rater reliability or respondent validation. In some instances results have been discussed in terms of statistical significance but not in terms of clinically meaningful interpretations of women's experiences (Posavac & Miller, 1990).

Recent critics (e.g., Adler et al., 1992; Cozzarelli, 1993; David, 1994; Wilmoth et al., 1992) have stressed that the varied characteristics of studies examining post-abortion emotional responses make it difficult to draw conclusions from the entire volume of existing research literature. Some studies, for example, have investigated a mix of women who had illegal, therapeutic and legal, elective abortions (e.g. Speckard & Rue, 1992). Adler et al. (1992) stated that such case studies are useful for generating questions about why abortion may lead to

psychopathological responses, but that these studies do not have adequate numbers of participants for determining normative post-abortion responses. Abortion research within the quantitative model has primarily aimed to determine the causal dynamics that result in given outcomes so that normative post-abortion responses may be established and universal laws of social behaviour may be constructed. By using this deductive form of logic, wherein research questions are tested in a cause-and-effect order, abortion research has totally neglected the significance and influence of the context on women's experiences.

Although some of the above criticisms have been lodged from within the quantitative framework itself, they clearly raise questions around the quantification of human behaviour. A central concern here is whether social interaction can be quantified accurately and whether it is a valid and meaningful reflection of the social reality of individual social actors. These questions serve to challenge findings that come out of research that has not considered the socially constructed nature of people's reality.

Clearly, then, the interpretation of research findings on post-abortion responses must consider the whole context of the woman's abortion experience as well as her participation in the description of her abortion experience. For example, some researchers believe that this should include the reasons for the occurrence of the pregnancy, the circumstances under which the decision to terminate the pregnancy was made and the type of abortion and its setting (Adler et al., 1992; Maforah & Wood, 1995; Wilmoth et al., 1992). Such considerations begin to illuminate the importance of viewing women's commonsense understandings of their abortion experiences as realities constructed by themselves. It also highlights the necessity of exploring

women's experiences of induced abortion within a framework that does not divorce socially embedded meaning from its embedding context.

In recent years the conceptualisations underlying qualitative research have increasingly formed the basis of inquiry into women's experiences. Predominantly, this trend has arisen from the awareness that the topic of women's lives is not universally homogenous, but sharply differentiated (Olesen, 1994); a formulation best appreciated by the qualitative research model. For example, black women have decried the tendency of white women 'to know us better than we know ourselves' (Olesen, 1994, p. 160), emphasising that the impact of such legacies as apartheid has created a sharply different past and present for black women to what it has for white women. It is noted that criticisms of this nature arise from the more general critique of 'defining the other', that is, invidious and oppressive definition of persons with whom research is done. In centralising the idea of definition of one's own reality, qualitative research attempts to recognise and validate the divergent experiences of social actors.

Unlike traditional modes of inquiry which have tended to absorb differences into dominant frameworks, qualitative research has created space for the subjective realities of individuals to be made more visible. In this regard, models of qualitative research have explicitly stated that 'it is important to centre and make problematic women's diverse situations and the institutions and frames that influence those situations ... in the interest of realising social justice for women' (Olesen, 1994, p. 158). This position has also served to illuminate issues around the absence and invisibility of women in research contexts, both as researchers and participants.

Deeply implicated in the very foundation of qualitative research is the issue of 'lifting of silence', so that voices of participants may be heard (Guba & Lincoln, 1994). This issue is further concerned with how voices of participants are to be heard, with what authority and in what form (Olesen, 1994). Data gathering and analytic procedures in the quantitative research modes have traditionally proceeded under hierarchical conditions found in the discipline, where participants are outside the account of their experiences. Moreover, increasingly more researchers, both women and men, are highly conscious of the absence of women's voices and distortions of women's experiences by male-oriented and -influenced frameworks. In this regard, abortion research has often been criticised for being male-dominated in the interest of restricting women's reproductive choices (Petchesky, 1984).

The concern with making participants' voices heard is related to the issue of language in qualitative research. Language is central to the construction of common symbolic forms, such as texts (Press, 1991). It is a dynamic form of social interaction which represents the lives and lived experience of individuals, and their organisation of cognitive meaning (Manning & Cullum-Swan, 1994). Recent research has explored the relationship between language and women's experiences. The pioneering work of Gilligan (cited in Press, 1991) on the voices of women examined the language with which women discuss ethical dilemmas in their lives, while Press (1991) looked specifically at women's modes of reasoning about abortion.

Within this context, there has been increasing support for the use of qualitative methods to enhance the understanding of issues peculiar to women (Griffin, 1986). In fact, some of the most skilful work on women's subjectivity and experiences has been done in the area of women's reproductive health (Clarke & Montini; Petchesky, cited in Olesen, 1994). This trend

towards qualitative inquiry has been in response to the growing acknowledgement of the complexity of the abortion experience and recognition of the limitations of the quantitative approach in illuminating the nuances of the abortion experience. Recent studies on induced abortion in Africa have confirmed the relevance and appropriateness of qualitative methodology to gain insight into the psycho-social aspects of the individual woman's abortion experience (Baker & Khasiani, 1992; McCulloch, 1996).

3.3 Aims

The aims of the study were as follows:

1. To explore participants' accounts of the factors that influence short-term post-abortion adjustment.

2. To identify, through participants' discourses, factors that may serve as 'risk factors' for the experience of short-term distress following induced abortion.

3.4 Participants

The target group, used in the study were black women who had undergone induced abortion within a period of three months to the date of the study being conducted. Five women who satisfied this criterion were included in the study. The number of participants selected was suited to providing the in-depth focus necessitated by the research problem. It also marked a saturation point; beyond this point, research generally tends to move the analysis away from

depth towards a numerical-survey modality (Nickerson, 1985). Qualitative researchers usually work with small numbers of people, rooted in their particular context and studied in-depth (Miles & Huberman, 1994).

It was found that selecting from the defined target group illuminated the factors under investigation, that is, the different factors that lead either to better or poorer post-abortion adjustment. It is suggested that these factors were best elucidated within the context of differences among women in the sample. Nickerson (1985) advocated that participants not be so narrow in their characteristics (age, ethnic, religious, economic status, etc.) that each replicates the other, and not so broad that each becomes a unique case and lacks commonality with the others.

In general, women in the target group appeared reticent to participate in the study. Initial attempts to invite women to participate in the study were unsuccessful. This, therefore, necessitated wider and more active advertising of the study, to be described later in the section.

The participants were self-selected by virtue of their voluntary response to a request to participate in a study on induced abortion. It is possible that the use of volunteers may result in a situation wherein the women who agree to participate in research differ from those who do not on characteristics linked to more positive or negative outcomes. An analysis of studies that provided data on characteristics of research participants versus the population from which the participants were drawn suggested that women who are more likely to find the abortion experience stressful may be under-represented in studies based on voluntary participation (Adler, et al., 1990). Quantitative researchers contend that the amount of bias introduced by this

sampling feature appears to be minor and unlikely to influence the general conclusions (Adler et al., 1990). However, bias and the generalisibility of findings are not key concerns in qualitative research. Furthermore, the present study was informed by the underlying principle that selection in qualitative research is primarily purposive, rather than random (Miles & Huberman, 1994).

Access to the participants was facilitated in the following ways:

a) Key informants - the researcher located informants who are knowledgable about induced abortion in South Africa. These included physicians and nurses in both the public and private sectors, community leaders, activists from women's organisations, counsellors and educators. The informants were briefed about the nature of the study and requested to identify potential participants who were then informed about the study.

b) Advertisements - the researcher utilised the media to publicise the research study and to invite women to participate in the study. An advertisement was placed in 'On Campus', the official newsletter of the University of the Western Cape. In addition, the researcher publicised the study during a radio talk show on abortion, on Radio C-Flat.

c) Informal network - an attempt was made to obtain participants through the researcher's personal and professional context; and by requesting further leads from initial interviewees. The researcher's professional context will be described in section 4.2.

A profile of the participants in the study is presented in Table 3.1. In order to preserve the anonymity of the five participants, names have been changed and certain identifying data excluded.

NAME	AGE	MARITAL STATUS	OCCUPATION	RELIGION	ABORTION PROCEDURE
Candice	30	Single	Student	Christian	Induced by medical practitioner
Lindiwe	20	Single	Student	Christian	Induced by medical practitioner
Yumna	31	Single	Clerk	Moslem	Induced by non-medical practitioner
Portia	25	Single	Factory Worker	Christian	Induced by non-medical practitioner
Ferial	24	Single	Social Worker	Moslem	Induced by medical practitioner

Table 3.1. Profile of participants

3.5 Interviews

This section will present the method utilised for data gathering, provide a rationale for its use in the current study, summarise its advantages and disadvantages and consider the role of the researcher in qualitative research.

The research interview, located within the qualitative paradigm, was the chosen method of data collection. The unstructured interview, in which no prespecified set of questions is employed (Brenner, Brown & Carter, 1985), was conducted on an individual basis. Recent social science enquiry has observed the development of the applications and techniques of interviewing (Bannister, 1994; Brenner et al., 1985; Marshall & Rossman, 1995). Unstructured interviewing has been proposed as the most important data collection medium in the social sciences (Fontana & Frey, 1994; Schurink, 1988). Accordingly, Schurink (1988) has argued for greater use of the unstructured interview in social research in South Africa, which has tended to utilise qualitative methodology in a role subordinate to that of quantitative methods of investigation.

Described as, 'a conversation with a purpose' (Kahn & Cannell, cited in Marshall & Rossman, 1995, p. 80), qualitative interviewing has been defined as 'any interaction in which two or more people are brought into direct contact in order for at least one party to learn something from the other' (Brenner et al., 1985, p. 3).

There are several reasons for using the interview as a qualitative research procedure. The interview is concerned with subjective meanings, that is, the meanings that participants accord to the topic of the interview; in the present study, induced abortion in South Africa. It allows

for the exploration of meaning by both parties. Brenner et al. (1985) motivated that there is sharing and negotiation of understanding in the interview situation which is less pivotal, if not completely absent, in other research methods. Accordingly, the interview method is the most appropriate and accessible means of obtaining information which is personally sensitive and revealing, and for which personalised questioning is required. Further, this method is best suited for exploratory studies. As a qualitative method, it can be used to uncover and understand what lies behind social-psychological phenomena about which little is yet known (Creswell, 1994; Strauss & Corbin, 1990); in this case, induced abortion in South Africa. It provides rich, context-bound information which may help explain a phenomenon (Creswell, 1994). The flexible character of the interview makes it possible to explore a variety of subject matter at different levels of detail and complexity (Brenner et al., 1985). Importantly, as a more open and flexible research instrument, qualitative interviewing can document perspectives not usually represented, and hence the approach can empower disadvantaged groups by validating and publicising their views and experiences (Bannister, 1994). Since the neglect of black women by social science research in South Africa is offered as one of the critical motivating factors for the study, the data gathering medium that was chosen was considered to best serve the research focus of the current study.

However, it needs to be acknowledged that interviewing also has disadvantages. It is time-consuming and labour-intensive. Due to the small number of participants in the present study, however, these factors did not have a significant bearing on the study. Other limitations include memory decay, distortion in data transformation and the poverty of conceptual frameworks to support the interpretation of data (Miles & Huberman, 1994). Brenner et al. (1985) also warned that the intimate nature of a face-to-face interview lends itself to intensive personal interaction,

which in turn might lead to increased bias. Furthermore, the research process may be seriously disadvantaged if the interviewer has poor interviewing skills. Given that the role of the interviewer in qualitative inquiry is central to the research process, this may impact significantly on the research findings.

The above discussion has alluded to two concepts which are central to any discussion of rigour in scientific research; reliability and validity. These concepts will be considered in section 3.7.

Finally, the development of the qualitative approach has witnessed persuasive arguments by its proponents that the researcher is the 'instrument' in qualitative studies; her presence in the lives of the participants is central to the paradigm (Marshall and Rossman, 1995). The researcher's attendance in the interview situation brings with it a range of interpersonal issues that are not central to quantitative approaches. In general, this includes building trust, establishing rapport, respecting norms of reciprocity and observing ethical considerations (Fontana & Frey, 1994). Since the carrying out of the study often depends exclusively on the relationship the researcher builds with the participant, interpersonal skills are paramount (Schurink, 1988). In this case, the researcher's training in psychology provided her with the relevant skills. This was evidenced to have a positive influence on participants' willingness to engage in thoughtful reflection.

To return to the present study, the interviewer employed a set of themes to guide an open-ended style of questioning. A topic guide format was used to assist with this process (see Appendix A). Schurink (1988) defined this process as unstructured interviewing using a semi-structured schedule or interview topic guide. The topic guide is a list of topics or themes that are pursued

in the interview, and consist of words or phrases that remind the interviewer of the theme of interest (Krueger, 1994), thereby ensuring that all the relevant sub-topics are covered during the interview (Schurink, 1988). The interview topic guide assisted in gathering basic socio-demographic and biographical information from the participants. It also referred to aspects of the abortion experience, including the circumstances surrounding the pregnancy, the decision-making process, the abortion procedure, the psychological impact of the abortion and how it was coped with. In order to limit researcher bias, broad and general theme-related questions were presented to the interviewee which aimed to focus her responses but predispose their content and organisation as little as possible. The choice of themes was advised by the results of recent research in the area; reviewed in the previous chapter.

The open-ended questioning style allows respondents the opportunity to develop an answer outside a structured format (Mouton, 1988), and to structure it in any of several dimensions (Krueger, 1994). Adler et al. (1992) found that studies that emphasised a narrow set of research questions restricted a fuller exploration of the wide range of women's post-abortion responses, and thereby compromised research findings. An advantage of the open-ended question is that it encourages individuals to respond on the basis of their specific realities (Krueger, 1994).

3.6 Procedure

Interview appointments were made with each of the participants, all of whom responded telephonically to the request for participation in the study. At these meetings, the interviewer informed participants about the nature and objectives of the research. It was briefly explained that the study aimed to explore black women's experiences of illegal abortion in South Africa,

and that the study held the possibility of contributing to the area of pre- and post-abortion counselling as well as public policy and debate on abortion legislation in South Africa. The researcher also provided participants with information regarding her credentials in order to reassure them that they would be interviewed by a researcher who possessed the skills required to facilitate the interview and who was committed to the ethical obligations implied by the research. According to Krueger (1994), providing sufficient background information to participants serves to minimise tacit assumptions about the nature of the questions, which in turn reduces the possibility of participants providing responses based on faulty assumptions.

They were then asked for their voluntary participation and reassured that their responses would be anonymous and confidential. The women were also assured that their participation in the study would have no legal or social repercussions. All five participants consented, and were interviewed individually. With the permission of the participants, the interviews were recorded with the use of audio equipment and transcribed verbatim (see Appendix D for transcripts). Transcripts do not include introductions, gathering of socio-demographic data, termination of interview sessions and referrals for psychotherapy. The transcription process involved close, repeated listenings to the recordings. This method of capturing the interview data was augmented by detailed note-taking immediately after the interview. The interviews were conducted in settings chosen by the women themselves. It was hypothesised that this would encourage the participants to feel comfortable and to respond honestly without fear of exposure. Two participants were interviewed in the researcher's office, two were interviewed at their own homes and one at the researcher's home. The interviews were up to an hour long.

In general, there was little difficulty in eliciting co-operation from the participants. The women shared their experiences in an open and insightful manner. The researcher's clinical skills appeared to facilitate the interviewing process, especially in providing support and containment to the participants when it was required. During the closure stage of the interview, participants were informed of counselling options in the event that they required professional intervention after participating in the study. They were also thanked for their invaluable contributions to the present study and arrangements were made to contact them at a later stage for the purposes of testing response validation and sharing the research findings with them. After completion of the study, the researcher contacted each participant telephonically to arrange to meet with her individually. The objectives mentioned above were achieved during these meetings.

3.7 Analysis of Data

The data was analysed through thematic analysis. This process involves an initial stage of systematically scrutinising and arranging interview transcripts. This is followed by synthesising and interpreting the descriptive data (Marshall & Rossman, 1995). It involves concurrent flows of activity; all of which entail data reduction as the mass of collected data is separated into manageable units, and interpretation as the researcher brings meaning and insight to the words of the participants in the study (Miles & Huberman, 1994; Marshall & Rossman, 1995).

The analytic procedures adopted in the present study were based on Marshall and Rossman's (1995) non-linear model for analysing qualitative data. Marshall and Rossman (1995) warned against tightly structured, highly organised analysing strategies which tend to 'filter out the unusual, the serendipitous' (p. 111). They suggest that this model strikes a balance between

efficiency considerations and analytic flexibility. In her research on women's socialisation, Marshall (cited in Marshall & Rossman, 1995) found that this analytic model guided the analysis of data without threat to the exploratory value of qualitative research or to data quality. It is acknowledged, however, that the chosen analytic scheme is just one way of managing qualitative data.

The above-mentioned model considers five modes of activity:

a) Organising the data;

b) Generating categories, themes and patterns;

c) Testing the emergent hypotheses against the data;

d) Searching for alternate explanations of the data;

e) Writing the report.

These analytic procedures will be explicated below.

a) Organising the data: this involved repeatedly reading through the data in order to become familiar with it. Silverman (1993) warned against the assumption that this is a less rigorous task as compared to the subsequent stages of analysis. Close and repeated reading allows the researcher to gain a holistic grasp of the data. Riley (1990, p. 47) referred to this as the 'hear what your data has to say' stage. During the reading process, people, events, quotes and ideas about emerging material constantly sifted through the researcher's mind. These were listed on note cards in order to make the information retrievable. Marshall and Rossman (1995)

highlighted this stage as being important in dealing with what seems overwhelming and unmanageable.

b) Generating categories, themes and patterns: the category generation phase demands a heightened awareness of the data, a focused attention to that data and an openness to the subtle, implicit intimations of verbal expression (Marshall & Rossman, 1995). Through the identification of salient themes, recurring ideas and patterns of belief that link people and settings together, it is possible to integrate the whole enterprise (Bannister, 1994; Marshall & Rossman, 1995). This required the researcher to question the data and reflect on the conceptual framework upon which the present study has been built. The aforementioned analytic exercise was contained within the assumption that there is an active participation of personal and social processes in the construction of reality, discussed earlier in the chapter.

The process of category generation involved a process of selecting, simplifying, abstracting and transforming the data. Coding categories were developed to assist with this procedure. The researcher searched through the data for regularities and patterns, and then wrote down words and phrases to represent these themes. Codes, therefore, served the purpose of assigning units of meaning to the descriptive information compiled during the study. The coding categories that were generated were influenced by the researcher's scrutiny of the transcripts, the theoretical orientation of the researcher and findings from previous studies in the area, reviewed in chapter two. The categories that were developed were as follows:

1) Circumstances surrounding the pregnancy;

2) The decision-making process;

3) Circumstances surrounding the abortion procedure;

4) Post-abortion psychological responses;

5) Coping with the abortion;

6) Counselling needs identified.

7) Women's responses after the abortion

Moreover, the issue of reliability received attention during this phase. Reliability has been defined as the degree of consistency with which instances are apportioned to the same category by different observers or by the same observer on different occasions (Hammersley, cited in Silverman, 1993). It has been increasingly emphasised that qualitative researchers can no longer afford to beg the issue of reliability (Mouton & Marais, 1990; Silverman, 1993). Consequently, inter-rater reliability checks were done on the coding of data. This involved using an independent rater to analyse the data. It is noted, however, that since the qualitative approach observes each and every social interaction as unique, the interpretations made by researchers are seen as reflections of the subjectivity of each and every researcher. Interpretations made by the researcher stand to be critiqued by others utilising this approach, who in generating alternative interpretations only add to the body of knowledge. This is founded on the assumption that there is no universal truth or 'scientifically objective' reality, so that all interpretations are valid within their specific context (Mouton & Marais, 1990).

Finally, the researcher used her experience and memory of the interview, which were captured in her post-interview notes, to support this process. These notes were seen as a resource, both in informing the analysis and in reminding the researcher of the assumptions she brought to the analysis.

c) **Testing the emergent hypotheses against the data:** during this phase, the researcher evaluated the plausibility of these hypotheses, through scrutiny of the literature on abortion, and tested them through the data. Marshall and Rossman (1995) recommended a process of searching through the data, during which one challenges the hypotheses, searches for negative instances of the patterns and incorporates these into larger constructs, if necessary. The researcher was satisfied that the data was useful in illuminating the questions under exploration, and therefore adequate in terms of its informational value, credibility, usefulness and centrality. This was achieved against the backdrop of the qualitative paradigm's concern with individuals' subjective understandings and constructions of social reality.

This process was not complete until the test for validity was performed. This was done after the fourth phase of analysis, to be described follow. Validity, with its concern for what is being measured, is directly relevant to the research interview (Brenner et al., 1985). Accordingly, the interviewer must demonstrate the extent to which the questions measure what is intended. Of note, here, is the notion that validity in qualitative research is also fundamentally linked to the researcher's interpretations. With this in mind, the researcher shared findings with the participants and requested them to comment on the accuracy of interpretation of their initial responses, which were elicited during the interview. Reason and Rowan (cited in Silverman, 1993) argued that good researcher goes back to the participants with the tentative results, and refines them in the light of the participants' reactions. This attempt for respondent validation confirmed the researcher's findings about the meanings that emerged from the data.

d) **Searching for alternate explanations of the data:** Marshall and Rossman (1995) maintained that as categories and patterns between them emerge in the data, the researcher's task is to

engage in the analytic act of challenging the very pattern that seems so apparent. The researcher therefore searched for alternate, plausible explanations for the data, and was satisfied with the ideas that were generated in the final analysis.

e) Writing the report: qualitative research does not separate writing about the data from the analytic process. This is based on the rationale that in lending meaning to raw data, through the choice of particular words to summarise and reflect the complexity of the data, the researcher is engaging in the interpretive act (Marshall & Rossman, 1995). This conception, therefore, highlights the researcher's own participation within the research process.

In this final phase of analysis, (a) the research context is described and (b) the data that was gathered through the interviews is presented. The participants' experiences, contained within their socially constructed worldviews, constitute the body of the report. The report will be presented in the next chapter.

3.8 Statement of Ethical Considerations

The study raised certain ethical concerns. Accordingly, consideration was given to the ethical interests of participants through the following procedures :

a) informed consent : obtaining consent from the participant after she had been informed about the research in a transparent manner.

b) confidentiality : providing an explanation of the procedures to be taken to insure the confidentiality of the information to be derived from the participant, thus protecting her identity.

c) protection from emotional harm : contracting to provide counselling should the participant require it after participating in the research.

d) feedback : offering to share the results of the research with the participants.

e) permission : securing permission from participants to disseminate information acquired by means of interviews.

CHAPTER FOUR

REPORT

4.1 Introduction

In qualitative research, reporting is not separate from analysis; rather it is analysis. Unlike conventional formats of reporting, which merely present research findings, the 'writing up' of the qualitative study is observed as intrinsic to the 'analysis', the 'theory' and the 'findings' (Miles & Huberman, 1994). This analytic stance invites the reader to be a co-analyst, that is, to examine the textual evidence of participants' responses (the transcribed text) and to weigh the researcher's interpretations and perspectives against this evidence (Erickson, cited in Miles & Huberman, 1994). In writing and presenting a public text, that is, the actual report, the qualitative researcher is re-interpreting participants' interpretations of their situations.

This chapter includes a description of the context within which the present inquiry was undertaken and participants' social constructions of their abortion experiences.

4.2 Context

Abortion research undertaken within the quantitative model has tended to ignore contextual factors related to the research itself. Although not explicitly stated, the assumption underlying the research appears to have been that abortion itself is such a critical event that the effects of the woman's social context and that of the research context are minimal. As highlighted in the

previous chapter, qualitative research repudiates such a notion by centralising the socially constructed nature of reality as well as the role of the researcher in the interpretation of participants' realities. Since a detailed discussion of the socio-historical context of abortion in South Africa has already been presented in section 2.2., only brief commentary will be offered below. This will be followed by reflections on the research process and the role of the researcher therein.

Reproductive health has been defined as 'the ability of men and women to undertake sexual activity safely, whether or not pregnancy is desired and, if it is desired, for the woman to carry the pregnancy to term safely, deliver a healthy infant and be prepared to nurture it' (Sai & Nassim, cited in Rogo, 1993). Nowhere else in the world is this ability less pronounced than in Africa. South Africa, for example, has a young population and a reproductive health profile characterised by high fertility, very low contraceptive prevalence and high maternal mortality rates. In the rural areas, access to contraception is restricted and in all areas, access to safe abortion is legally and/or logistically remote. This has resulted in the prevalence of induced abortion under unsafe conditions.

There is increasing recognition that abortion, as a means of fertility control, reflects the social and economic conditions under which black South African women live. The extent to which apartheid has functioned to undermine black women's roles in society has been well documented (Dyer, 1994). Furthermore, entrenched sexism and the patriarchal nature of South African society has denied many women their basic human rights, among them, the right to reproductive freedom. This has served to maintain women's oppression and sense of disempowerment.

However, South Africa's restrictive abortion policy has not deterred women from seeking abortion. As already reported, an estimated 200 000 to 300 000 South African women undergo illegal abortion each year. Both single and married women, due to social and economic pressures, are choosing abortion as a means of family planning. In addition, the proportion of induced abortion has been reported to increase with the level of education and the opportunity for employment (Rogo, 1993).

The above considerations were found to typify the experiences of the women in the present study. The prohibitive influence of the present abortion policy had forced all the participants to procure 'back street' abortions in order to terminate their unwanted pregnancies. The majority of the women interviewed came from economically disadvantaged backgrounds. For all the women, however, unwanted pregnancy was experienced as undermining of their attempts to establish economic stability for themselves and, sometimes, for their family structures. The unplanned pregnancy threatened participants' educational and employment opportunities. It is the researcher's perception that, through their reproductive decision-making, the women were confronting and challenging the oppressive influence of both socio-political and patriarchal subordination on their lives. This was demonstrated, for example, in their impassioned plea for greater reproductive freedom for South African women. It was interesting to note that not all the women had supported the right to choose prior to their abortion experiences. At the time of the interview all had positioned themselves as pro-choice.

However, a tension was observed between participants' 'liberatory' discourse on abortion and their descriptions of its psycho-social impact on their lives. Some participants' were unable to reconcile the experience of 'it was my choice' with the post-abortion experience of 'it felt like

a loss'. It is suggested that the general social discourse on abortion has functioned to polarise abortions' socio-political significance from its emotional significance. For example, restrictive abortion policy is often justified on the grounds of deleterious post-abortion responses. For all the participants, this tension appeared to have been further influenced by religious prohibitions on abortion. To this end, the women reflected on their 'badness' for choosing abortion as a means of fertility control. Furthermore, the illegal status of 'back street' abortion reinforced feelings of 'having done wrong'. Despite their pro-choice position on abortion, participants appeared to have taken on the script of abortion as 'criminalised', thus contributing to the general sense of oppression and disempowerment experienced by the majority of black South African women.

The above descriptions suggest that, for the women that were interviewed, abortion is embedded in a complex social and personal context. The complexity of the abortion experience will be elucidated in section 4.3. while the research process is explored below.

Within the interview context, all the participants appeared comfortable and eager to narrate their experiences. They shared their experiences with insight and openness. Some of the women experienced high levels of affect during the course of the interview. Candice and Lindiwe felt that the interview had re-evoked unresolved feelings of sadness and loss around the abortion. However, Candice was not uncomfortable with her expression of difficult feelings and, in fact, reported her ventilation of feelings as therapeutic. However, Lindiwe appeared somewhat anxious and uncomfortable with her feelings. Furthermore, she gave the impression that she expected social disapproval from the researcher. Her anxiety was clearly evident during the initial stages of the interview; Lindiwe appeared hesitant and seemed to inspect the interviewer's

responses for evidence of condemnation. In this regard, Yumna presented very differently. She spoke with self-assurance and appeared more trusting of the interviewer. She conveyed a sense of acceptance and responsibility for her abortion decision. She reflected that the interview situation had allowed her the opportunity to lift the silence around her abortion experience. Similarly, Portia appeared relieved to talk about her experience. She was relaxed throughout the interview and narrated her experience in a matter-of-fact, yet open, manner. Ferial gave the impression of being deeply introspective. She appeared to consider her responses carefully before responding to the interviewer's questions. However, this did not present any difficulties for the interviewer since she gave an articulate and candid account of her abortion experience.

Conducting the interviews demanded consideration of reflexivity on the part of the researcher. The researcher is trained in psychology and presently works as a student counsellor at the University of the Western Cape. Her professional training was found to favour the adoption of a self-reflective posture through the research process. Her training and psychotherapeutic experience also equipped her with the interviewing skills necessitated by the nature of the inquiry.

In general, the researcher had little difficulty establishing rapport with the participants. It was found that providing participants with information regarding the researcher's professional credentials and her ethical obligations to them allayed their anxiety somewhat. Much of this happened at the initial contact which, in turn, appeared to prepare participants for the actual interview. During the initial stage of the interviews, the researcher was cautious about posing focused questions for fear of their potential intrusiveness. Given that at this stage she knew very little about the participants and how they had coped with their abortion experiences, she found

it 'safer' to invite the participants to begin talking about what was most comfortable for them. This strategy eased both the researcher's, as well as the participants' initial anxiety. It also allowed the researcher to thereafter pursue in-depth questioning within an interpersonal context characterised by trust and rapport.

The researcher's professional background appeared to have evoked a different kind of anxiety for Ferial. From a similar professional background, she shared with the researcher an academic understanding of interviewing and its process. However, this resulted in her feeling somewhat self-conscious and guarded initially. It was the researcher's impression that she felt pressured within herself to demonstrate a high level of insight into her abortion experience. In retrospect, the researcher realised that she, in turn, had taken on less of a professional persona in order to minimise Ferial's anxiety. This was evident in the manner in which she had asked questions, as well as in her non-verbal communication in the interview setting.

In the interviews with Candice and Lindiwe especially, the researcher was required to provide containment and support of a therapeutic nature as a result of their levels of distress. This sometimes created a tension for her in terms of the mutually established boundaries of the interview session, that is, it was generally understood by the researcher and the participants that the session was primarily to gather information for research purposes and not to provide counselling. Mostly, this tension was managed by reflecting the participants' feelings on a surface level. Whilst this prevented the session from taking on a strong counselling flavour, it may have discouraged depth reflections from the participants at times.

Some of the above-mentioned observations on the research process raise questions on the issue of power relations in research. According to Bannister (1994), research sets up, and is conducted within, power relationships. For example, the researcher was in the position of having privileged knowledge both of the participants and of the experience of conducting the interviews. These differences in position between the researcher and the participants may have influenced power relations in the research context. The researcher was aware of the presence of the power dynamic in the research relationship and attempted to minimise this by framing the research process as a collaborative exercise which not only involved the full participation of the participants but also implied responsibility on the part of the researcher to be accountable to the participants. The issue of accountability has already been discussed in section 3.8. In this way, qualitative research strives to undertake research in a non-dehumanising and non-exploitative manner.

Bannister (1994) proposed that qualitative researchers also consider the extent to which class, race, gender and age relations, for example, interact with the interviewing relationship. In the present study, the researcher's positioning as a black woman appeared to have facilitated disclosure and reflexive commentary on the part of participants. Being middle-class appeared to have had no significant influence on the research process. 'Culture-bound' interpretations of the experience of abortion, information on the use of different abortifacients across cultures and the accessing of traditional healers in the pre- and post-abortion period, as documented by Bradford (1991), did not emerge. It is unclear whether participants were silent on these issues as a result of cultural differences between them and the researcher or whether these issues were simply not a part of their repertoires on abortion.

Furthermore, the researcher had chosen to be transparent about her pro-choice position on abortion. It is the researcher's impression that this may have influenced Portia, in particular, to assume the identical position in order to please her. Yumna, on the other hand, appeared to have experienced this self-disclosure on the part of the researcher as facilitative. In general, though, self-disclosure did not appear to inhibit the research process significantly.

The issue of the researcher's interpretations of participants' descriptions also merits attention here. It is acknowledged that in the interpretative enterprise, the researcher was, to some extent, influenced by the theoretical framework emanating from past research, reviewed in Chapter Two.

Finally, it is acknowledged that the constructive and inexhaustive nature of the analysis was experienced as both frustrating and dissatisfying by the researcher. The partiality of interpretation, typical of qualitative analyses, left the researcher with a sense of incompletion and uncertainty around what was included in the final report and what was not. Bannister (1994, p. 65) advised that qualitative researchers should allow for the uncertainty of incomplete analysis as 'an index of the arbitrary limit imposed by writing up. In principle the research process could continue almost indefinitely ... in the analyst's shifting perceptions of their interpretations'.

Against this background, it is suggested that the literature review, as presented in Chapter Two, is but one version of women's experiences of induced abortion. The remainder of this report, will present another. It will explore themes emerging from participants' descriptions of their abortion experiences.

4.3 Themes

Participants' social constructions of their abortion experiences is presented within an analytic, interpretive framework. Here, inquiry is directed into the processes by which the women had come to describe their experiences, in an attempt to illuminate the influential, determining factors shaping their experiences. The researcher's interpretations are presented in the form of thematic categories that were developed to assign meaning to the descriptive information compiled during the study. The analysis follows the usual chronology of the abortion experience, from the discovery of the pregnancy, to the decision-making process, the circumstances surrounding the abortion procedure itself, the emotional outcomes of the abortion experience and coping with the abortion. In addition, counselling needs that were identified by participants are reviewed. Finally, women's responses after the interview are explored.

4.3.1 Circumstances Surrounding the Pregnancy

In investigating psychological responses to abortion, one necessarily explores responses to the entire experience of becoming pregnant and of terminating the pregnancy. Since abortion inevitably occurs in the context of pregnancy, assumptions about the nature of such pregnancies are then central to any inquiry into women's post-abortion responses.

Pregnancy involves a wide range of psychological, biological and cultural influences. For the women that were interviewed, the pregnancy experience incorporated a repertoire of meanings and definitions about the nature of the pregnancy, the control of fertility and responses to the pregnancy.

4.3.1.1 Circumstances of Conception

It is generally understood that at the time of an abortion, the pregnancy that is terminated is not wanted by the woman. However, there may be dissimilarities in the extent to which it is unwanted and the reasons why it is not wanted.

For Portia, it was relatively easy to define the aborted pregnancy as unwanted. She stated:

> I was traumatised about the pregnancy when I found out, I had not planned to have a baby, so I did not want it. I was clear about it from the beginning.
>
> (Portia)

However, for Lindiwe, who was highly ambivalent about her abortion decision, the boundary between the degree of wantedness and unwantedness of the pregnancy appeared blurred and confusing:

> I didn't want it in my life, I never intended to have a baby ... I don't know really, I had mixed feelings because I remember ... it felt good that I had a baby inside of me and I didn't want just to give it up ...
>
> (Lindiwe)

The definitions attached to the nature of the pregnancy suggest that 'wantedness' is related to the extent to which positive and negative emotions are experienced in relation to the pregnancy and the expected child; illustrated by *I was traumatised about the pregnancy, it felt good*. The

above quotations also reveal that the term 'unwanted pregnancy' is used interchangeably with 'unplanned' or 'unintended pregnancy'. Adler (1992) suggested that while the three definitions overlap significantly, there are also conceptual differences among them. She interpreted 'unplanned' and 'unintended' as both referring to the circumstances under which conception occurs. Planning involves the conscious process of deciding whether or not to have a child. However, as discussed later, a woman's intention regarding pregnancy may or may not be consistent with her planning behaviour.

Consistent with the findings of Adler (1992), two potential categories of intention emerged; the woman who is motivated to avoid conception and the woman who is conflicted due to either internal or external concerns. Three women in the present study conformed to the second description. In this instance, the women were motivated to avoid conception, but did not make a conscious choice to facilitate the desired outcome.

The woman's intention appeared to influence her post-abortion emotional responses. According to Major and Cozzarelli (1992), a woman's intention is likely to have a more persuasive connection with her post-abortion emotional responses than her planning. For participants, intention reflected their motivations with specific regard to pregnancy, while planning was reflective of a wider range of issues, including a generalised sense of control. Lindiwe, for example, who experienced some intentionality to her pregnancy reported to be significantly distressed after the abortion. She became depressed and needed to see a counsellor as a result. Participants' post-abortion responses will be discussed in section 4.3.4.

Women's descriptions of the different sets of definitions characterising the terminated pregnancies, elicited reflections on the meaningfulness of the pregnancy. Lindiwe and Candice, in particular, had mixed feelings in relation to the 'wantedness' and intentionality of the pregnancy. They appeared to value the pregnancy more and hence felt that they had lost more by terminating the pregnancy than did Portia and Yumna, for whom the pregnancy was completely unintended and unwanted. Congruous with previous findings (Major et al., 1985; McCulloch, 1996), it was found that those who attached more meaning to the pregnancy experienced greater decision difficulty which in turn led to poorer post-abortion adjustment. However, the relationship between meaningfulness and intentionality appears to be complex. Candice described the experience of meaningfulness in terms of the affinity she felt with the pregnancy:

> ... there was a baby inside of me. Umm (tearful), the longer that I held on to it, the more connected I became to it. I could see a lot of physical changes ...
>
> (Candice)

From the above extract, it is evident that the relationship between meaningfulness and intentionality was influenced by mediating factors. For Candice, an advanced pregnancy and its associated physical transformations influenced an initially unintended pregnancy to be later experienced as meaningful. Whilst the factors influencing this relationship and the specific nature and process of their mediating persuasion did not fully emerge in the present study, it is clear that this concern deserves further attention. It would be useful to investigate which aspects of their negative life experience individuals find to be meaningful, in what ways they are

experienced as meaningful and whether an experience that is perceived as more meaningful is also more valued.

Clearly apparent, though, is the indication that while planning and intention are related to the conditions under which conception occurs, wantedness can refer to any time during the term of the pregnancy. It is observed that unintended conceptions sometimes evolve into wanted pregnancies and intended conceptions into unwanted pregnancies. If pregnancy is planned and intended, it is likely to be wanted. However, subsequent life events and circumstances, such as loss of a partner, may lead to an initially planned, intended and wanted pregnancy to become an unwanted conception. Major and Cozzarelli (1992) noted that the circumstances resulting in this change may themselves be the basis of post-abortion distress. Therefore, in exploring responses to abortion, it is crucial to consider both the circumstances of the conception as well as those following conception.

It is suggested that whilst a conception that is unplanned may be unintended or unwanted, these relationships do not necessarily follow. Consequently, to capture a fuller understanding of women's post-abortion responses, all three facets of the conception, as well as subsequent circumstances and changes in feelings about the pregnancy, should be taken into account.

4.3.1.2 Contraception

Historically, the dominant discourse on contraception has focused on the socio-political determinants of contraceptive practice. For example, Cope (cited in Jagwanth, 1994) asserted that the previous South African government had used its policy of apartheid to control fertility

so that the white population would not be numerically dominated by the black population. In addition, some feminists have argued that contraception has served to perpetuate the personal, social and economic subordination of women within a patriarchal context (Petchesky, 1984).

Nonetheless, there is much recorded evidence to attest to the desire of humans to control their powers of reproduction and their conscious efforts to do so. However, contraceptive behaviour is not necessarily an accurate reflection of fertility control and planning. It is influenced by several factors, not just by desire to conceive or to avoid pregnancy. Researchers have cautioned against the assumption that a pregnancy that occurs in the context of contraception is unplanned, unintended and unwanted, while a pregnancy that occurs in the absence of contraception is planned, intended and wanted (Adler et al., 1992; Lazarus & Stern, 1986). In support of this supposition, the following discursive themes emerged.

Yumna, Portia and Candice reported to have conceived as a result of contraceptive failure:

> ... I took the pill ... and it didn't work ... I'd been on the pill for a while so obviously something went amiss, and I took it regularly.
>
> (Yumna)

> We used condoms, I don't know what happened but it didn't work.
>
> (Portia)

> ... I was sexually active, I was on the pill. I changed pills at the time, and I'm not a good pill-taker, so it was not impossible. (Candice)

The above descriptions suggest that pregnancies resulted from both 'mechanical' (*it didn't work*) and 'behavioural' (*I'm not a good pill-taker*) failures. Since contraceptive methods are not infallible, some pregnancies will result from contraceptive failure even when methods are used correctly. However, behavioural influences, such as lack of knowledge and inconsistent and incorrect use of contraception, frequently appear to be the cause of failure, and may explain some of the disparity between theoretical and actual failure rates (Ross, cited in Adler et al., 1992; Wood & Foster, 1995).

In this study, behavioural failure and non-use of contraception were also attributed to an unacknowledged or unconscious desire for pregnancy:

> Sometimes we used condoms, other times nothing. I don't know, umm ... maybe I wanted to, er ... have a child.
>
> (Lindiwe)

> I did not use any contraception. Sometimes I wonder if that was because a part of me unconsciously wanted to have a child and so I fell pregnant. It may very well be, umm ... I'm not quite sure.
>
> (Ferial)

Although the women were not always able to access the unconscious meanings attached to the desire for pregnancy, they demonstrated some degree of awareness in this regard. They perceived the occurrence of unwanted pregnancy as being related to possible intrapsychic tensions and contradictions within themselves, and the unwanted pregnancy a manifestation of

these internal conflicts. The present investigation did not allow for depth exploration of unconscious motivations for the pregnancy.

The women's attributions for non-use revealed that failure to use contraception does not necessarily measure intention to conceive. Non-use of contraceptive methods also point to various interpersonal barriers which render the issue of contraceptive use more complex than merely the possession of accurate knowledge or intent (Wood & Foster, 1995). For example, Ferial and Lindiwe interpreted non-use of contraception as resulting from their perceived sense of invulnerability:

> I don't know, I just thought that it wouldn't happen to me. When I think about it now, I realise how foolish I was. How could I have thought that I was invulnerable when all around me women were having unplanned pregnancies?
>
> (Ferial)

> I suppose I thought that things like that happen to other people. I was always the one who did things the right way, the proper way. I did not break rules, umm, norms. So I just ignored the whole issue because it was never going to be my problem. Huh! Until it happened to me.
>
> (Lindiwe)

Ferial reflected that her social constructions of sexual activity contributed to her failure to use contraception:

> It was intense and passionate, just what I want from my sexual relationships. So it was like there was no place for whipping out condoms. [Laughs]. It doesn't explain why I didn't use something else. Maybe, I got something out of it, like, umm, you know, it was exciting at the same time. I could live on the edge, ja, but nothing was going to happen to me.
>
> (Ferial)

A salient theme that emerged was that of gender-role expectations. Within the dominant discourse on women's sexuality, women's ability to initiate and negotiate contraceptive use is constrained since their sexuality is viewed as passive or only complementary to men's sexuality (Wood & Foster, 1995). The above discourse was highlighted in the following descriptions offered by Lindiwe:

> If he didn't have any condoms, then I didn't feel free to tell him that we shouldn't have sexual intercourse, so then we didn't use anything.
>
> (Lindiwe)

> ... it's not comfortable for me say this, but before the abortion, mostly I allowed my boyfriend to take the lead, to make all the decisions ...
>
> (Lindiwe)

However, Ferial demonstrated awareness of a more 'permissive' discourse on women's sexuality, which views women as equal partners in the sexual relationship (Wood & Foster, 1995):

> So even though I feel strongly about my sexuality and about taking responsibility for it, umm, I mean it was no less my responsibility as it was his, well, uhh, I didn't. So there's no excuse, I was simply irresponsible. But also he wasn't saying anything about contraception, and he'd been around, so I wasn't going to upset things.
>
> (Ferial)

Clearly, the above extract also reflects the presence of contradictions and tensions within Ferial's representation of her sexuality. Here, there is a subtle suggestion of the influence of power relations on contraceptive practice; reflected by *he wasn't saying anything* and *I wasn't going to upset things*. For Ferial, this compromised contraceptive negotiation and use in her sexual relationship.

The set of characterisations of contraceptive practice suggests that it is inappropriate to make inferences about the extent to which a pregnancy was unplanned or unintended and is presently unwanted based on the woman's reported contraceptive use at the time of conception. This assumption oversimplifies the dimensions of pregnancy.

4.3.1.3 Responses to the Pregnancy

Participants reported varying responses to the discovery of the pregnancy. Responses were influenced by individuals' social constructions of the experience of unplanned, unintended or unwanted pregnancy and by their interpretations of the reasons for its occurrence.

A frequent response to initial discovery of the pregnancy was shock and disbelief:

> I couldn't believe it, it was the end of the world ... I felt like "How's my life going to work out?"
>
> (Portia)

> When she told me that I was pregnant, ja, I was shocked. I hadn't suspected that I was pregnant so it came as a huge shock.
>
> (Lindiwe)

> Emotionally, it was a shock to my system. It was something that I was not expecting ...
>
> (Yumna)

It was not uncommon for women to experience mixed feelings about the pregnancy. Candice and Ferial stated:

So it was a mixture of things - Oh, my god, what am I going to do about this, devastation, but at the same time there was a baby inside of me ...

(Candice)

I was distressed, concerned about what was going to happen because I had not planned for this, but in a way that was difficult to understand, I felt secret pride, umm, pleasure, I don't know what it was, it's difficult to explain except to say that it was a positive feeling.

(Ferial)

In the second extract, the phrases *difficult to understand, I don't know, difficult to explain* clearly highlight the confusion that may result from mixed responses to an unintended pregnancy. To the extent that this confusion contributes significantly to ambivalence about the abortion decision, it is likely to predispose women towards negative post-abortion sequelae. An elaborated discussion on issues of ambivalence will follow later in the chapter.

In Candice's case, circumstances prior to discovery of the pregnancy were found to influence her initial reaction:

... I went to a gynaecologist and she said that she thought that I had a growth of some kind ... and then I went for a scan because she thought something was wrong ... and then it was a very, very tiny baby ... so there was relief on that level.

(Candice)

The relief experienced by Candice may have also been related to a regained sense of control over her body, resulting from confirmation of the pregnancy.

The experience of unwanted pregnancy often challenged women's perceived sense of reproductive control. For Ferial and Portia, it confronted them with feelings of powerlessness and lack of control:

> There was this feeling of events, significant events like issues around fertility and reproduction, had overtaken me and there was nothing that I could do about it, umm, you cannot undo a pregnancy and it made me feel so, er ... impotent ...
>
> (Ferial)

> ... I was not in charge of the situation, I didn't like the feeling ...
>
> (Portia)

Furthermore, responses were found to change according to changing circumstances or as a result of specific experiences related to the pregnancy itself. For Ferial, the experience of the ultra-sound had a marked impact on her response to the unwanted pregnancy:

It changed for me when I saw the picture from the ultra-sound. I did not feel anxious anymore, or uncertain, or umm, like I didn't know what was happening in my body. I don't know, I felt calmer. I knew now what I was dealing with. But you know, Shahnaaz, this also complicated things for me a whole lot. Now, it was a baby, my baby, umm, and in that instant I wanted it, I wanted it so badly. I felt confused about my decision to abort, did I still want to do it? Umm, this was one of the most difficult moments in the whole process.

(Ferial)

The above extract also makes reference to the impact of ambivalent feelings on Ferial's decision-making process. As indicated already, a discussion of this is to follow.

The responses reported above were also found to influence personal attributions for the pregnancy. Of the various psychological factors that have been related to adjustment to negative life events, perhaps the most prominent have been attributions for the event (Mueller & Major, 1989). In this regard, two women in the current study were inclined to blame themselves for the occurrence of unwanted pregnancy:

... I blamed myself for the pregnancy because I had not been responsible with contraception knowing the consequences.

(Ferial)

... it was my fault that this happened ... I should have been more careful.

(Lindiwe)

In these instances, self-blame appeared to be an adaptive coping response because it signified belief in personal control over the woman's reproductive outcomes. Major et al. (1985) defined this as self-behaviour blame, which involves an attribution to controllable aspects of the self, and distinguished it from self-character blame, which involves an attribution to uncontrollable aspects of the self and is a self-deprecating response. In the current study, self-behaviour blame did not appear to be related to post-abortion adjustment. By implication, the above findings support previous findings that women who blame their pregnancy on another person, such as their partner, or on their character are more likely to experience adjustment problems after the abortion.

As already noted, the above descriptions alluded to the relationship between responses to the pregnancy and decision-making around the abortion. A detailed discussion follows.

4.3.2 The Decision-Making Process

The abortion decision is complex, involving a wide variety of influences. Typically, women's abortion decisions are made within the multifarious context of her relationships and life choices. In South Africa, women's decisions are further influenced by a socio-cultural environment that is hostile to abortion as a reproductive choice. Within this psycho-social climate, some women describe the abortion decision as stressful. Nevertheless, as highlighted in Chapter Two, studies of psychological responses to abortion generally reveal that most women do not experience significant distress from the procedure. Against this backdrop, understanding the realities of the lives of women who are in varying life stages, who have differing roles and responsibilities and who come from different economic backgrounds is crucial. Exploring the influence of these

factors on the decision-making process will shed light on the factors that influence post-abortion adjustment.

In the analysis to follow, participants' motivations for seeking abortion are discussed. The discussion is framed in terms of personal (internal) and situational (external) reasons for abortion. It is noted, however, that internal and external reasons are not necessarily distinct from each other and may present some degree of overlap across categories. For the purpose of this analysis, classification was determined in terms of the site that best translated women's interpretations of the reasons for abortion.

4.3.2.1 Personal Reasons

Personal reasons that the women extended as motivations for seeking abortion included their personal belief system, lack of preparedness for childbearing and the desire to avoid single parenthood.

4.3.2.1.1 Personal Belief System

In the present study, the abortion decision tapped into women's personal belief systems. It raised questions about religious convictions and political and social values held by the woman. Adler et al. (1992) concluded that generally favourable attitudes towards abortion, a favourable opinion of the abortion option and a less punitive internalisation of religious doctrine is related to satisfaction with the abortion decision.

Women in this study belonged to the Christian and Islamic religious faiths. Both these religions prescribe the right to life and condemn abortion as sinful. The non-affirmative influence of religion resulted in differing degrees of value conflicts and moral concerns for the women. Women who reported decreased conflict were those who held strong views on women's right to choose.

Three women described their personal positions as follows:

> From my religious perspective, it's not allowed. On that basis, my family and my community is vehemently opposed to it. But I feel differently. It's *my body* and it is *my right* to make decisions about it. I really feel strongly about that, you know Shahnaaz.
>
> (Ferial)

> ... my religious background ... it is pro-life ... I'm pro-choice. Umm ... more than the religious guilt ... I believe women should make those decisions for themselves.
>
> (Candice)

> ... Islamically ... abortion is prohibited ... and falling pregnant when you're not married and single ... how my family would have reacted because of the religion part of it ... it wouldn't have been very pleasant ...
>
> (Yumna)

In talking about the influence of religion on their abortion decision, both Ferial and Yumna made reference to their families. Whilst Ferial appeared clearer about her position on abortion, Yumna did not verbalise her own feelings on this issue. The silence around this may have been a result of unresolved tensions within her own conceptualisation of abortion and religion. By presenting her family's position as anti-choice, she implied her own to be pro-choice. However, it is possible that this was a pseudo position adopted in order to undermine the stress and tension that may have been generated by the presence of religious conflict.

For Candice, motivation for abortion based on a pro-choice stance did not exclude the negative influence of prohibitive moral imperatives, as illustrated by her reference to *religious guilt*. A discussion on the influence of religious belief on women's post-abortion responses is more appropriately located within the discussion on abortion outcome, to follow later in the chapter. However, it is important to note that to the extent that participants believed that the decision to abort was the personally correct one, they reported better post-abortion adjustment.

4.3.2.1.2 Lack of Preparedness for Childbearing

Three of the women reflected that at the time of conception they had felt emotionally unready and not mature enough to assume responsibility for childbearing and raising a child:

> I was too young, at the time I felt like you can't suddenly become a mother. You have to think about it or plan for it and then you will feel more prepared to be a mother.
>
> (Portia)

I was not ready to have a child. I was still busy discovering myself, umm, still maturing. I couldn't trust that I was adult enough to have this child. I guess I didn't want to take that risk.

(Ferial)

... I wasn't emotionally ready for such a commitment and responsibility ... having a child and bringing it up ... is quite a responsibility and you have to be ready for that, you have to be prepared for that and I wasn't ...

(Yumna)

In Ferial's case, her awareness and acceptance of her personal immaturity for raising a child appeared, in fact, to be some measure of emotional maturity with respect to making the abortion decision.

4.3.2.1.3 Desire to Avoid Single Parenthood

For Portia and Lindiwe, feeling immature to raise a child was closely associated with the desire to avoid single parenthood:

We didn't have any marriage plans and if the relationship didn't work, then I'd have to raise the child by myself. I don't think that I ... it would have been very difficult for me, I felt more like a young girl than a woman in this situation.

(Portia)

> I simply wasn't ready to be a single parent. The relationship was not in a good way, he was on his way out, and I was going to be left alone with the baby. As a single parent you need, umm, financial resources, and er ... good support, and I didn't have some of that ... definitely not the money.
>
> (Lindiwe)

In the second extract, there is evidence of the combined influence of personal and situational reasons on the abortion decision. For all the women in the study, there were multiple reasons for terminating the pregnancy. Reasons related to situational factors will be examined in the next section of this chapter.

To conclude this section, it was found that women who chose abortion based on careful consideration of their personal attitudes and feelings towards childbearing as well as their personal beliefs and attitudes towards abortion, appeared more satisfied with the abortion decision. These findings are consistent with the outcomes of previous inquiries which revealed that women whose motivations are internally based and who, therefore, consider their decisions to be personally meaningful, cope well with their abortion decisions and suffer minimal negative post-abortion consequences (Adler et al., 1992; Lemkau, 1988; Russo et al., 1992).

However, there was subtle evidence to suggest that some of these influences are not static. That is, women may shift their interpretations to being internally based during the process of deliberating on the abortion decision and possibly thereafter too. It is hypothesised that this is a way of managing internal tensions and contradictions so that the abortion decision is perceived as the correct one, thereby promoting satisfaction with it. Past research has not revealed this

dynamic and the present study only claims to identify its possible presence in the decision-making process. Further investigation in this regard is therefore required.

Furthermore, personal motivations resulted in perceptions of personal control and elevated self-esteem, which in turn appeared to increase self-efficacy for coping with the abortion. Yumna captured these nuances succinctly when she expressed how she felt about her decision:

> I felt like this was the right thing for me. I made the decision, I took responsibility, umm ... I took charge of my situation. And so, I felt good about myself ... and if that's how I was feeling ... well, I was going to cope with it.
>
> (Yumna)

Several researchers have demonstrated that feelings of self-efficacy for coping with abortion are strongly related to better post-abortion adjustment (Cozzarelli, 1993; Major et al., 1990; Mueller & Major, 1989). An elaborated discussion of coping with abortion will be presented later in the analysis.

4.3.2.2 Situational Reasons

External reasons were more salient in the decision-making of the women in this study. The women reported that their economic circumstances influenced their decision-making, they had education and job responsibilities, they had difficulties within their partner relationship, felt coerced into the decision and feared family disapproval.

4.3.2.2.1 Finance Related

The negative effects of poverty on South African women and their families are well documented (Women's Health Project, 1995). This situation is compounded by the fact that, in South Africa, maternity benefits are not guaranteed to pregnant women and the State provides minimal assistance to single parents (Klugman, cited in McCulloch, 1996).

Within this socio-economic context, insecure and unstable financial circumstances characterised the economic position of all, but one, of the women in the study. There appeared to be an interesting difference in the personal interpretations of economic influences on decision-making across socio-economic status.

The women who identified themselves as economically disadvantaged expressed concern about the financial burdens of raising a child:

> As a student, my mother, who is also a single parent, is supporting me, and it's a struggle for both of us. I would never manage with a child, and nowadays it is so expensive to bring up a child.
>
> (Lindiwe)

> ... financially I was not in a position ... I has some insurance policy and there was a loan of about R2000 to R3000, R2800 in fact against it ... but then I sat down and realised that R2800 would not go a far way.
>
> (Candice)

As far as financially, I wasn't stable enough and also I didn't have any support from the man I was having a relationship with ...

(Yumna)

... you need financial preparation, and I certainly couldn't afford to have a baby, not with my wages. I also contribute at home and we sometimes struggle to make ends meet. Even if my boyfriend supported me, we still wouldn't have managed financially because he also doesn't earn a lot of money.

(Portia)

Although perceptions of satisfactory economic conditions for raising a child were not elicited in the present inquiry, it is apparent that the women considered lack of income and inadequate financial resources as factors pivotal to the decision-making process.

A vastly different perspective on financial concern was provided by Ferial, the only middle-class woman in the study:

At the time it, umm, was not financially impossible to have the child. I had just qualified and had a good job. There would have been financial support from other quarters. But, I had this concern about giving up my financial independence and all that .. it meant to *me*.

(Ferial)

Although Ferial possessed the financial resources to have a child, she experienced childbearing as a threat to the economic stability that she enjoyed. In this situation, it is hypothesised that the threat of loss of income was a less influential factor than the accompanying threat of loss of independence that was implied by continuing with the pregnancy. In general, women in the study related loss of independence to external considerations in their lives. However, it is important to recognise that perceived loss of independence inevitably impacts on internal characteristics of women's lives as well, possibly resulting in negative feelings such as lowered self-esteem, helplessness and hopelessness. In the above extract, the impact on internal aspects of one's life is illustrated in the participant's emphasis on *me*. In this case, however, more specific interpretations of impact on the sense of self did not emerge.

To summarise, socially and economically disadvantaged women were found to be over-represented in the present study. It is, therefore, suggested that socio-economic status plays a dominant role in black women's decisions to abort. These findings document participants' perceptions of the substantial childrearing responsibilities facing black women in South Africa. Furthermore, the findings once again confirm the complexity of the interplay between external and internal reasons and the abortion decision. More evidence of the intricacy of the decision-making process is provided in the remainder of this section.

4.3.2.2.2 Education and Job Responsibilities

Opposition to the oppression and inequality of women in South African society is supported by arguments for the social upliftment and economic empowerment of women. Within this context,

women's access to educational and career opportunities is considered to be critical in meeting the obligation for the reconstruction and development of South African society as a whole.

In keeping with this position, the women in this study emphasised the value of educational and vocational pursuits in their personal lives. They expressed the desire for optimal performance in their educational and career settings. Carrying an unplanned pregnancy to term was perceived as an obstacle to their immediate-term educational and career objectives.

The students, Lindiwe and Candice, indicated that decision-making involved effecting a choice between continuation of the pregnancy as opposed to continuation of their academic studies:

> I really wanted to finish my studies.
>
> (Lindiwe)

> ... I was at university and it also meant making decisions around that. It is a set programme and it meant that if I had this baby I would not have been able to complete my studies and I was feeling very insecure about that 'cos it was very important to me, it meant a whole lot of things in terms of my independence, but also it brought up my own insecurity around my academic and professional work, so it was that kind of edge, that kind of uncertainty about myself, whether I could care for a baby.
>
> (Candice)

The second extract clearly illustrates the depth of reflection that is demanded by the abortion decision-making process. Here too, there is testimony of the combined influence of personal and situational motivations for termination of pregnancy. For Candice, threatened loss of a highly valued externally-based experience appeared to heighten tension around the possible accompanying loss of highly valued characteristics related to her sense of self; *independence, security and certainty*.

The career women, Ferial and Yumna, expressed identical sentiments:

> I guess I also didn't want to give up my job, it was new and offered potential ... I am invested in making a success of my career, I see myself and my career in that kind of way.
>
> (Ferial)

> ... I'm doing well in my work and having a baby would have jeopardised that.
>
> (Yumna)

It appeared, thus, that the intent to fulfil educational and career responsibilities was related to positive self-perceptions. It would follow, then, that positive self-attributes would be indirectly sustained through termination of pregnancy. Cozzarelli (1993) found that positive personality traits, if they remained largely intact through the pregnancy and abortion process, contributed to successful post-abortion adjustment. These and other predictors of coping with abortion will be explored in another section of the chapter.

4.3.2.2.3 Relationship with Male Partner

Given that pregnancy is an occurrence for which two people are responsible and that the decision to obtain an abortion often involves both a woman and her male partner, surprisingly little is known is about how male partners conceptualise the abortion experience, and how male partners' appraisals of the pregnancy and abortion affect women's adjustment. The present investigation explored men's responses only to the extent that they related to women's psychological adjustment to abortion. This section will describe relationship dynamics as they influenced motivations for abortion, whilst relational influences on women's coping and adjustment will be analysed in a later section.

For four women, the duration, nature and level of commitment present in the relationship with the partner was related to the abortion decision:

> We had just met, it was a new relationship. Neither one of us knew where it was going and ... umm ... that was fine for me. But the pregnancy put pressure on the relationship to either become something or to be able to hold a baby. And that's a major commitment. Really, we didn't know each other well enough to make that commitment, so ... umm ... yes, that also affected my decision.
>
> (Ferial)

> The one thing that made it difficult to consider having the baby was that it wasn't a very stable relationship at the time and also that I was involved in another relationship at that time too ... so in terms of relational stuff, it was difficult
>
> (Candice)

> ... we were going out for a short time and it wasn't a great relationship, we quarrelled a lot.
>
> (Lindiwe)

Yumna, who was involved with a married man, stated:

> ... I didn't have any support really from the man I was having a relationship with because he was married and obviously had commitments ... he was angry ... and also he made it quite clear that he was not able to take the responsibility in any way, and that I would be responsible totally because he wasn't prepared for any kind of commitment.
>
> (Yumna)

The quality of the relationship appeared to be a weighty factor in decision-making. This was emphasised by Candice who stated that:

> ... I was sharing a house with the person ... and it was extremely difficult emotionally, partly because of what I brought but also because of how he related. And then I needed relief ... I made contact with the other person ... it was such

> a breath of relief and sunshine ... and it was so affirming to be with someone who respected you, liked you ... umm ... who wanted to be with you. And I went back to the other person and there was this withdrawn person, he seemed to be depressed ... and I made a decision. I said to him, "I'm going to go through with the termination".
>
> (Candice)

Clearly, participants' abortion decisions were affected by characteristics or actions of their male partners. Major et al. (1992) found that men who coped poorly with the pregnancy and abortion and who were preoccupied with their own efforts to cope with the situation to the extent that they were unable to provide effective support to their partner, had a negative effect on women's own coping expectancies and post-abortion adjustment. Under these circumstances, a man with poor coping skills may become an additional burden to a woman already attempting to cope with an unplanned, unintended or unwanted pregnancy. Not only must she take care of herself emotionally, but she must also worry about the emotional well-being of her male partner, and possibly, the future of their relationship together. Whilst it is acknowledged that the need for *relief*, as stated in the above account, may have been in relation to the unplanned pregnancy itself, it is hypothesised that the desired relief for Candice was also related to the burden of difficult relationship dynamics.

In the following depictions, by Candice and Lindiwe, the impact of difficult interpersonal experiences within the partner relationship is recounted:

This person was quite withdrawn at the time and it was extremely difficult to make contact with him. He alluded to ... of possibly taking his life at the time, which was very difficult for me. Yes, it felt like there was quite a bit of pressure.

(Candice)

... I said maybe we must wait a bit before we decide for sure ... let's first talk and see. All he could ... say ... was that, he said that he can't wait and that I must know that otherwise he's out and that's one of the things that forced me to have an abortion.

(Lindiwe)

It emerged consistently that the abortion decision was related to the influence of external factors in the decision-making process, more specifically, coercion from the partner. This is illustrated in the words *pressure* and *forced*. The following quotations are examples of two women's interpretations of the influence of both overt and subtle forms of coercion from partners:

... the relationship in which I conceived was not a very supportive one. The person there was more invested that I terminate ... yes, there was a lot of that [coercion].

(Candice)

I felt extremely manipulated ...

(Candice)

I ... was convinced in many ways that this is what needed to happen.

(Candice)

... he said, "No you can't do that" [have the baby] ... that I must just have the abortion ... there were times that I felt that he forced me and that was very stressful for me.

(Lindiwe)

The extent to which having an abortion was the woman's own choice was found to play an important role in her response to the procedure. Candice and Lindiwe, who experienced coercion from their partners, reported that the presence of coercive social transactions in their partner relationships contributed to decision difficulty and increased levels of stress. Numerous studies have investigated the effects of perceived social support and perceived social conflict of the woman's abortion decision (Adler, 1979; Major et al., 1990; Major et al., 1992). Results have suggested that the presence of non-supportive or conflictual transactions is related to poor post-abortion adjustment. However, no research has directly addressed the issue of social coercion and its impact on women's post-abortion psychological responses. In the present study, the strongest negative reactions were found to occur for Candice and Lindiwe, who were themselves ambivalent about terminating the pregnancy but who were persuaded or coerced to do so by their partners. Negative post-abortion responses will be explored in section 4.3.4. Although inconclusive, these findings appear to bear parallels with reported outcomes on the influence of social support and social conflict. In recognition of this, one major goal in counselling a woman seeking an abortion should be to determine whether the decision is the

woman's own, and to provide her with the opportunity to discuss her choice with an unbiased person. An elaborated discussion of counselling issues will follow later in the report.

Having stated this, it is acknowledged that the connection between decision-making and support is complex. For example, Yumna stated that the abortion decision was hers alone:

> ... I made the decision by myself ... it's my body, my life, my decision ...
>
> (Yumna)

Whilst this position was empowering and left her feeling generally satisfied with her decision, there appeared to have been some tension between her decision and what she would have liked. This is reflected in the following quotation:

> ... he wasn't very supportive ... and in the end I knew it had to be my decision...
>
> (Yumna)

The phrase *had to* suggests a perceived lack of choice in this situation. This is, in fact, confirmed in the following extract:

> Had the circumstances been different, if he had been supportive ... I would have considered [having the child].
>
> (Yumna)

In the cases of Portia and Ferial, as well, the decision was taken primarily by themselves. Unlike Yumna's situation, their decisions were made within supportive relationships:

> He said that he would support any decision that I made and I felt no pressure from him either way. So I was lucky in that way.
>
> (Portia)

> My partner and I discussed it. He said that it was my decision and that he would support whatever decision I made.
>
> (Ferial)

Although it did not emerge directly, the experience *of it was my decision* appeared to have left Ferial feeling alone and perhaps even unsupported by her partner in the decision-making process. Compared to the other participants, she was relatively silent about her partner relationship and her feelings about its influence on the abortion decision. Whilst she did make some reference to her partner relationship, he appeared to be mostly absent and distant in her descriptions of the abortion experience.

The above discussion suggests that support may have different meanings for different women in the abortion decision-making context. Past research has focused on the construct of support as one that has singular meaning for lay-people. The above reflections indicate that this may not be the case. It is, therefore, highlighted that the abortion experience needs to be explored in terms of the unique meanings that it generates for each woman.

The above discussion of relationship dynamics and women's motivations for abortion will be supplemented with a review of participants' accounts of the influence of family relationships on the decision-making process.

4.3.2.2.4 Relationship with Family

In general, investigation into the impact of family members' responses to pregnancy and abortion has focused on the consequences of positive and negative family-related social interactions on women's adjustment to abortion (Adler et al., 1990; Miller, 1992; Major et al., 1990). Few studies have directed inquiry into the extent to which family relationships contribute to women's reasons for termination of pregnancy.

In the current study, none of the women disclosed the knowledge of their unplanned pregnancies to their families. They justified their lack of disclosure as follows:

> I couldn't tell my mom that I was pregnant, she would have been very disappointed.
>
> (Lindiwe)

> ... in terms of family support it would have been very difficult because this relationship was not condoned or supported in any way by my family ... so it was extremely difficult.
>
> (Candice)

> Given who they are, they'd expect me to have a child within a marital relationship. Oh no, it would have freaked them out completely ... more stress for me.
>
> (Ferial)

> I think that my mother would have kicked me out of the house ... something like this had never happened in our family ... I'm like the hard-working one in the family, the responsible one ... so that's why I think they would have taken it badly.
>
> (Portia)

> ... falling pregnant when you're not married ... how my family would have reacted because of the religion part of it and because they are quite orthodox and all of that so it wouldn't have been very pleasant, and they definitely wouldn't have accepted it.
>
> (Yumna)

It surfaced that the women feared disapproval from family members and, consequently, did not expect support from them. In some cases, their expectations of censure were related to the fact that their pregnancies had occurred outside the institution of marriage. It is also likely that the decision not to tell family members about the pregnancy was a means of managing potentially unsupportive and conflictual responses to the subsequent abortion decision. Although these findings provide no indication of how participants' families would have actually responded to them, they do suggest that family members' perceived reactions to the pregnancy and abortion

may be an influential determinant of women's adjustment to the abortion experience. In their study on perceived social support and adjustment to abortion, Major et al. (1990) established that women who told their families were less likely, on average, to perceive them as completely supportive than those who told either their partner or their friends. It was, thus, implied that family members who are told of the *abortion* often do not provide the level of support that is required by the woman. However, this outcome offers no prediction of family members' responses to the *pregnancy* itself, and the impact of their responses on decision-making. Clearly, then, the implications of critical and non-supportive responses to the pregnancy, from family members, merit further attention.

4.3.2.3 The Issue of Ambivalence

Finally, the discussion on participants' interpretations of the abortion decision is concluded with a brief commentary on the experience of ambivalence in the decision-making process.

The decisions of most of the women in the study were characterised by some degree of ambivalence about the abortion decision. It has been suggested that decisions about childrearing, or about pursuing the options that limit childbearing, are of such consequence, that ambivalence is the norm (Lemkau, 1988). Participants' descriptions highlighted the experience that there is no painless way of dealing with an unwanted pregnancy.

Three women represented their ambivalence as follows:

At times I fantasised about having this baby ...

(Candice)

... knowing that there is a baby growing inside of you, I pictured what it would look like, what it would feel like to be a mother ... I thought of my child everyday ... I even thought of names for my child.

(Lindiwe)

... sometimes I fantasised about being a mother, even being somewhat of a family, that is, me, my partner and our baby.

(Ferial)

Candice, Lindiwe and Ferial demonstrated a high level of understanding about the factors that contributed to their ambivalence:

... there was a lot of ambivalence around having the abortion. You see, I was set on having it, it was something that I wanted to do ... it seemed right. But the longer I had the baby inside of me, it became increasingly difficult. I was fourteen weeks when I terminated so it was a long time into the pregnancy. So the ambivalence made it worse for me. It was extremely stressful and I think ... umm ... at the end of the day I'm not sure if I really sorted through about having this baby or not but was just being pulled in two directions which most of the time made it very difficult.

(Candice)

... I just couldn't have a baby ... but like I said ... it was also ... confusing, mixed. It's just that knowing that there's someone growing inside of you.

(Lindiwe)

It changed for me when I saw the picture from the ultra-sound ... you know, Shahnaaz, this also complicated things for me a whole lot. Now, it was a baby, my baby, umm, and in that instant I wanted it, I wanted it so badly. I felt confused about my decision to abort, did I still want to do it? Umm, this was one of the most difficult moments in the whole process.

(Ferial)

The above extracts, and particularly references to *the baby*, hint at feelings of attachment to the potential child. According to Speckard and Rue (1993), attachment to the foetal child may occur despite the desire to terminate the pregnancy and be freed of a crisis pregnancy. For these women, specific events and circumstances, such as a second trimester pregnancy, appeared to have contributed to some form of attachment and subsequent ambivalence. These findings are supported by previous outcomes which have established that women who delay into the second-trimester are more conflicted about the abortion decision.

In addition, repeated and consistent use of the word *difficult* in this context suggests that attachment-related ambivalence may result in increased difficulty with the abortion decision. As previously mentioned, a difficult abortion decision is a risk factor for the experience of negative post-abortion feelings, such as grief and depression. The extent to which women in the current study presented with post-abortion distress will be explored later in the chapter.

Finally, it is concluded that the issue of ambivalence has implications for counselling, particularly pre-abortion intervention. This will also receive attention in subsequent sections.

4.3.3 Circumstances Surrounding the Abortion Procedure

Surprisingly little attention has been awarded to the effects of the social environment surrounding the abortion procedure itself. Some researchers have proposed that psychological risks do not vary with legislation on abortion (Ney & Wickett, 1989), while others have suggested that women who undergo illegal procedures are at greater risk for negative post-abortion effects (Adler, 1979).

Women in the present study underscored the significance of the circumstances surrounding 'back street' abortion in their constructions of the abortion experience. Their descriptions highlighted the extent to which attempts to procure the abortion, the abortion procedure itself and treatment by the abortion provider influenced their interpretations of the abortion experience.

4.3.3.1 Procuring the Abortion

Due to the restrictive abortion policy, none of the women had considered the option of legal abortion. As a result, their attempts to procure abortion were all directed at accessing 'back street' abortion providers. In general, information about 'back street' abortion services was easily available to the women. Most of the women knew of a friend or a 'friend of a friend' who had personal experience with abortion and agreed to provide the relevant information. The network for information was, therefore, oral and informal. Ferial, Lindiwe and Portia stated:

Finding someone to do it wasn't a problem. One of my friends knew someone whose girlfriend had an abortion. He obtained the contact details from this friend and all I had to do was make the phone call. Umm, it was strange ... I had to speak in coded language when I called this woman, and she in turn spoke in codes. She indicated that she would perform the procedure at my house, umm ... for security reasons, it would be safer to do it that way.

(Ferial)

Before my abortion, I had heard that some doctors do it for you, and I asked this person, this lady that I knew, I told her everything and she told me about this doctor that might help me ... she said that she wanted to be anonymous in all of this.

(Lindiwe)

My boyfriend knew someone, a family friend, a nurse, and she gave him the name of a person who performed abortions.

(Portia)

Phrases such as *it was strange, I had to speak in coded language, for security reasons, it would be safer, anonymous,* all highlight the clandestine nature of illegal abortions. The criminal status of illegal abortion has implications for both the woman undergoing abortion as well as the person providing the service. Fears of prosecution, therefore, result in illegal abortions being performed under surreptitious circumstances.

Portia and Ferial communicated that they wanted to protect the identities of those who had terminated their pregnancies but expressed how the secrecy impacted on them:

> I cannot talk about who did it ... er ... well, it's a secret. But it makes me feel like I did something illegal.
>
> (Portia)

> I feel loyal to the person who helped me. If he is exposed, he will not be able to help women like myself. But .... I resent how all this makes me feel, it's like I'm a criminal. (Ferial)

Pro-choice activists have spoken out strongly against the present abortion law which criminalises the thousands of South African women who undergo abortion each year (Dyer, 1993). Although the experience of having done something *illegal* and feeling like a *criminal* did not appear to have direct negative consequences on the women's adjustment to abortion, it contributed to the experience of stigma and the resulting resistance to talk about the abortion experience. Women's interpretations of abortion as a stigmatised experience will be reviewed in section 4.5.

Finally, participants made reference to the financial implications of procuring an illegal abortion. Ferial, Lindiwe and Yumna were charged high fees for the abortion service:

> My first attempt to induce cost me R2000, a whole lot of money, and the second attempt cost me slightly less. My partner and I shared the costs.
>
> (Ferial)

It cost me something like R1000, but I was desperate so I borrowed some money and I used some of my bursary money.

(Lindiwe)

It cost me a lot of money [R1500], money that I didn't have, but when you're in dire straits, you get the money from somewhere.

(Yumna)

For Ferial, Lindiwe and Yumna, the level of desperation in combination with access to some financial resources made the concern over financial costs a secondary issue. However, the problem of access created by economic restrictions is a reality for most black women in South Africa. This, in turn, not so much discourages women from procuring illegal abortions, as is confirmed by the high statistics, as it informs the choice of method to terminate the pregnancy.

4.3.3.2 The Abortion Procedure Itself

The method of procuring abortion generally depends on who induces the process and where it is induced. In response to these considerations, Rogo (1993) described three categories: qualified nurses and physicians, ill-trained paramedical and non-medical individuals in the community and self aborters, made up of desperate, poverty-stricken women. She found that women from urban areas accessed the first two categories of people while women based in rural areas generally relied on people from the community or self induced. In this study, two patterns emerged: abortions were obtained from professional medical practitioners and from untrained practitioners in the community. It is important to note that the women in this study were all

from an urban area and had some access to medical services. Furthermore, methods of procurement of abortion varied with the place, competence of the abortion provider, gestation and availability of equipment or drugs.

Ferial, Candice and Lindiwe, who consulted medical practitioners, reported that the procedures were performed in the practitioners' consulting rooms, under anaesthesia or heavy sedation. The most commonly practised method to terminate pregnancy was dilation and curettage (D&C):

> He performed a D&C in his surgery. I was under general anaesthetic. But at some points I was vaguely aware of him working on my abdominal area ... and at some point my eyes opened and I saw that he had all these instruments in his hands and there was blood everywhere.
>
> (Ferial)

> He did a D&C. Because I was fourteen weeks, he used forceps. He used some anaesthetic, local, but I could feel everything. I could feel how he pressed on my tummy ... umm ... I could feel when he tugged, when he pushed and he pulled, I felt a lot of pressure on my lower back. It was painful, I remember feeling ... that I was not going to make it. I kept thinking, 'I'm going to die, I'm going to die ...'
>
> (Candice)

> ... I was drowsy so I'm not sure what he did at first. And then, I think he cut the placenta and I just felt the blood and everything coming out ... it was like

birth pains and it lasted for about two to three hours ... but I didn't want to see the child.

(Lindiwe)

The above accounts are vividly descriptive of the abortion procedure and what it entailed for the women undergoing it. For example, Ferial's and Lindiwe's descriptions present evocative images of *blood*. Blood that is associated with women's reproductive processes can be experienced and interpreted as either a normal, healthy part of women's sexuality or as an uncomfortable, even dysfunctional aspect of their sexuality. Although it is unclear as to how exactly Ferial and Lindiwe interpreted their experience of blood, it is possible that the mere context of the abortion procedure and the meanings associated with it resulted in blood being interpreted as antithetic to reproductive well-being. It is also possible that this experience was both distressing and frightening for the women.

Candice and Lindiwe, the two women who aborted second trimester pregnancies, appeared to have experienced greater physical trauma. Adler (1979) reported that procedures used in later pregnancy are likely to be more stressful than procedures used in early pregnancy. They are usually more prolonged and painful and sometimes involve labour pains which result in the delivery of a dead foetus (Adler, 1979). Research findings have also pointed to more serious psychological sequelae following terminations of mid-trimester pregnancies (Adler et al., 1992). Psychological outcomes of abortion will be analysed later in the report. These findings raise concern about the post-abortion psychological health of the many South African women who are confronted with difficulties of access because of restrictive legislation, and who may encounter

delays in accessing illegal abortion providers since information in this regard may not always be readily available.

The community practitioners, on the other hand, provided a service aimed at inducing vaginal bleeding, with instructions to the women to thereafter proceed to a public hospital in order to obtain a D&C. They mainly used rubber catheters, inserted into the cervix, to induce bleeding:

> This person used a thin tube to help start the bleeding ... by that evening, I experienced some pain, almost like menstrual cramps, and I started bleeding. I went to the hospital and told the doctor that I had a miscarriage, and they performed the D&C.
>
> (Portia)

> She inserted this tube into my vagina and pushed it far up into my abdomen, probably into my cervix ... this was supposed to induce bleeding, well it didn't. I waited and I waited and still no bleeding. By now I wanted it to be over. You know I hated that waiting, you have no control over what's happening. Well, I went back to her, umm ... this time she wanted to dry out my uterus, whatever that means. This freaked me out, it sounded terribly unsafe and I didn't trust her with my body and really, my life. I said, "No thank you", and I found a doctor who was prepared to do it. Of course she refused to refund my R2000.
>
> (Ferial)

... it was a tube kind of thing that she used. She used it to pump some kind of liquid into me ... after the procedure was done she explained ... that I would start bleeding, and it would be almost like a heavy period. She said that I must go to the hospital if I possibly got an infection or maybe take anti-biotics ...

(Yumna)

Four of the women experienced extreme pain. They said:

... I remember lying on the bed and feeling like I was going to die, it was extremely uncomfortable, painful 'cos it was quite advanced ... (Candice)

The pain was severe, during and after. But there was no escaping it, you had to live with it because of the choice you made.

(Ferial)

It was so painful ... and he said that there was still more to come ... and I felt like telling him to just stop.

(Lindiwe)

... it was painful, it was this sharp pain inside.

(Yumna)

The above descriptions are powerful accounts of what women are forced to subject themselves to in order to control their reproductive freedom. The methods of procuring illegal abortion are

clearly both physically and emotionally traumatic. The risks to women's physical health and to their lives are clearly illustrated in participants' depictions; *it was painful, I was not going to make it, I'm going to die, it sounded terribly unsafe, I didn't trust her with my body and really my life*. The experiences reported by the women in this study are a reflection of the basis on which the pro-choice lobby in South Africa argues for the present law to be repealed. More reproductive freedom for women is equated with less physical pathology and lower mortality rates for the women of this country (Dyer, 1994).

In her study of South African women's experiences of induced abortion, McCulloch (1996) did not report any differences in women's experiences of legal and illegal abortion. However, it seems likely that a legal abortion will have a markedly different impact on a woman than an illegal procedure. In most cases, legal procedures are performed relatively quickly and safely. In contrast, illegal procedures confront women with *the waiting* and *lack of control over what's happening*. Feelings such as these, contextualised within a social milieu antipathetic to abortion, are perceived to heighten the sense of powerlessness that women experience in the course of terminating their pregnancies.

Within this context, women's experiences of the individuals who performed their abortions emerged as a further consideration in understanding the impact of the circumstances surrounding the abortion procedure.

4.3.3.3 Treatment by Abortion Provider

It is important to recognise that the responses of abortion service providers may affect women's responses to the procedure as well as their post-abortion adjustment. Generally, studies on this particular relationship have focused on treatment by staff in clinical settings that offer legal abortion services. Adler (1979) established that negative treatment of abortion patients by staff may contribute to poor post-abortion adjustment. Negative responses from abortion providers usually include disapproval and hostility towards the woman. In the present study, there was no evidence of negative treatment by the individuals who performed the abortions. Whilst Portia had been treated at a hospital after her abortion had been induced in a 'back street' setting, she had presented herself as a miscarriage patient. She appeared to have experienced no difficulties with the hospital staff.

Participants understood their treatment by abortion providers in relation to the meaning that the service held for the practitioners themselves. Candice and Ferial attributed the response of abortion providers to their pro-choice position on abortion whilst Yumna interpreted it in relation to the occupational meaning that it held for the practitioner:

> It was a gynaecologist ... [he] was sympathetic to women who wanted to terminate, and he did it for a very cheap price ... I think he cared and that's why he did it, he certainly didn't do it for financial reasons.
>
> (Candice)

He seemed to be pro-choice. He was understanding of my predicament and er ... I did not experience him as judgemental. In fact he was very supportive, he took me home after he was done.

(Ferial)

This was her business, I gave her money and she did the job. I don't think that she saw her role to be anything else. So I didn't expect anything from her, and umm ... you know, she didn't treat me badly.

(Yumna)

References to *he cared, he was understanding, [not] judgemental, very supportive, didn't treat me badly* reveals what women experience as positive in their interactions with practitioners of abortion procedures. The implications that these suggestions hold for abortion counselling will be discussed in later sections.

It is interesting to note the extent to which the above descriptions present abortion providers as 'human' and sensitive to the women's circumstances. It is speculated that the script that participants conferred upon the abortion providers held an important function for the women themselves. That is, it allowed them to frame their experiences as humanised and sanctioned, even if only within the confines of the practitioner's room. It can be reasonably assumed that the abortion procedure may be dehumanising and humiliating for some women. Yet, participants were relatively silent about the impact of the abortion procedure on their sense of person.

Another theme that emerged in relation to abortion providers was the lack of communication that characterised the contact between them and the women. Ferial and Candice reported:

> She didn't really tell me what she was going to do. All that she said was that she would induce bleeding and I was to go home and wait for the bleeding to start and then to go to hospital.
>
> (Ferial)

> ... he didn't engage much ... he attempted at the time to provide some counselling ... but that was clearly not what he was into, he expected you to be quite worked out about your decision once you got to his office.
>
> (Candice)

Baker and Khasiani (1992) expressed concern about the lack of information and absence of counselling evident in these situations. It has been suggested that a woman's reaction to abortion may be influenced by whether or not she receives counselling and by the type of counselling she receives (Lemkau, 1988). Clearly, the illegal abortion setting does not favour the provision of counselling interventions to women requiring them. It is, therefore, hypothesised that since the circumstances surrounding illegal abortion deprive most women of the opportunity for pre- and post-abortion support, women who undergo illegal abortion procedures may then be at risk for negative post-abortion sequelae. This hypothesis is examined in greater detail in the section to follow.

Clearly, the possibility of less restrictive abortion legislation in the near future necessitates further investigation into the influence of treatment by hospital staff on women undergoing abortion. It is also suggested that this consideration cannot be separated from the psychological effects of abortion on medical staff, an issue that has received little attention in South Africa.

4.3.4 Post-Abortion Psychological Responses

A plethora of research has been undertaken to determine women's post-abortion psychological responses. As already noted, findings have unanimously concluded that induced abortion does not lead to deleterious psychological consequences for most women. Instead, a range of outcomes is possible, depending on the influence of various factors inherent to the abortion experience. In keeping with this conceptualisation, the present section examines the scope of participants' post-abortion psychological responses in relation to the factors that influenced their development.

The findings will be discussed according to Adler's (1979) categorisation of the factors that account for variations in post-abortion emotions experienced by women: positive emotions, socially based emotions and internally based emotions. The two latter categories represent the negative emotions experienced by women.

4.3.4.1 Positive Emotions

Relief has been shown to be the predominant reaction associated with abortion (Adler et al., 1992; Lazarus & Stern, 1986). Congruous with previous outcomes, the present study indicated

that relief was the most commonly experienced positive emotion immediately following the abortion procedure:

> Mostly, I felt relieved, the pregnancy was finally terminated.
>
> (Ferial)

> [relief] yes, because I could continue with my studies.
>
> (Candice)

> ... I just felt so relieved that it was all over and that I could now get on ... that I didn't have to worry about this unwanted pregnancy anymore.
>
> (Portia)

> ... I felt relieved because I could just get on with my life and not be burdened with the responsibility of having this child because I wasn't ready for it. (Yumna)

> Well, after the abortion I just felt quite relieved because it was now over.
>
> (Lindiwe)

It is apparent that the sense of relief experienced by women was related to an experience of closure around the abortion, suggested by the terms *finally* and *it was all over*. In addition, closure offered the opportunity to *continue, to get on*; indicative of the extent to which abortion is perceived to resolve the crisis of an unwanted pregnancy.

Although minimal research has been undertaken to address the long-term psychological consequences of abortion, a recent study suggested that, for most women, the feeling of relief tends to persist over time (McCulloch, 1996).

Moreover, it emerged that while the positive emotion of relief was experienced strongly by all the women in the study, responses to abortion are not uni-dimensional. More specifically, the experience of positive emotions did not prohibit the experience of socially and internally based negative emotions. These negative emotions are reviewed below.

4.3.4.2 Socially Based Emotions

Adler (1979) defined socially based emotions as those post-abortion feelings that reflect the social stigma and norm violation associated with unwanted pregnancy and abortion. In the present study, these feelings were identified to be guilt and shame. Both these feelings have been recorded to be common responses to abortion (Zolese & Blacker, 1992).

> ... I also judged myself quite a lot, like why did I do that. I felt guilty ... I couldn't go to church for a while because of what I was feeling.
>
> (Lindiwe)

> ... my own guilt, some of it linked to my religious background ...
>
> (Candice)

But I also felt a little bit guilty because of what I had done.

(Portia)

... I felt ... guilty ... guilt because of the fact that I won't say murdered a child, but I suppose some people would say that I had to get rid of a human life.

(Yumna)

Yumna's account of her feelings reveals some tension around her interpretation of the experience of guilt. She states that her feelings of guilt were related to other people's perceptions of abortion. However, in the above extract, she appears to be unconvinced about her own position on whether abortion constitutes murder of an unborn child or not. In the following extract she contradicts the position of *I won't say murdered a child* by stating that:

... it wasn't easy ... to accept the fact that this is a life and it was like murdering a child and getting rid of something that could be alive ...

(Yumna)

Here, Yumna owns the belief that abortion is murder. Clearly, such a position may be extremely difficult for women to accept and to reconcile it with the abortion decision. Thus, it may be less complicated for a woman to represent the position that abortion is murder as that of other people's rather than her own, as is clearly illustrated in Yumna's case.

The above extracts also point to the relationship that exists between guilt and religious belief. Romans-Clarkson (1989) confirmed that negative religious attitudes to abortion predispose a

woman to post-abortion feelings of guilt. A discussion on the personal meanings that participants attributed to the dialogue on abortion and religion was advanced in section 4.3.2.1.1. Therefore, the above descriptions serve to confirm that women who act against their religious beliefs are at risk for post-abortion feelings of guilt.

Shame, on the other hand, was predominantly related to the negative social views that essentially characterise social discourse on abortion in South African society. There was a nuanced difference between those women who had internalised negative social constructions on abortion and those who themselves were more impervious to social judgements but who nevertheless found themselves vulnerable to the consequences of negative social attitudes on abortion.

Portia's and Lindiwe's descriptions typified the former characterisation of shame. They stated that:

> I feel ashamed about it, umm ... I know that I did something wrong.
>
> (Portia)

> I also judged myself quite a lot ... I felt bad about it ...
>
> (Lindiwe)

It is suggested that these women's responses were influenced by their internalised frames of reference which accorded negative personal meanings to their abortion experience. The use of words such as *wrong* and *bad* indicates the presence of negative self-perceptions related to the abortion experience.

Women in the second category, however, were relatively free of rigid self-internalisation of 'good' and 'bad'. Instead they reacted to the threat of social disapproval that typifies society's responses to abortion. Yumna and Ferial articulated that:

> ... I don't feel like I've done a terrible thing. But other people will probably say that about me and that's why I feel ashamed to say anything about it.
>
> (Yumna)

> I certainly don't feel ashamed about it inside of myself ... umm, but I'm extremely aware of the fact that most people, certainly where I come from, are majorly anti-abortion, they have very negative attitudes towards abortion. So I feel some of that because I can't talk about my abortion to others.
>
> (Ferial)

Perceptions of social disapproval also seemed to have placed restrictions on women's freedom to *say* and *talk* in relation to their abortion experiences. It is hypothesised that the criminal status of women's 'back street' abortions further contributed to their constructions of abortion as a stigma. The influence of social stigma on women's interpretations of the abortion experience has been documented in previous studies (Maforah & Wood, 1995; McCulloch, 1996). Primarily, stigmatisation of the abortion experience forces women to conceal their feelings and to deal with the experience in isolation. This may be an adapted way of dealing with the stress that is anticipated to arise from people's negative reactions to the abortion decision. However, this may serve to undermine women's attempts to elicit social support and

to cope with the abortion. An exploration of this supposition is presented later in the report.

4.3.4.3 Internally Based Emotions

Adler (1979) defined internally based emotions as those emotions that relate to the loss of the pregnancy and the meaning it had for the woman. For women in the present study, this class of negative emotions included depression, anxiety, regret and anger. Researchers have emphasised that these feelings are common after abortion and may be expected in the short-term period following abortion (Adler et al., 1992; Major & Cozzarelli, 1992).

The following quotations reflect some of the internally based emotions identified above:

> ... shortly after the abortion ... I would feel extreme anxiety. I had to get medication for a short while.
>
> (Candice)

> I felt some degree of regret after the abortion. Although it's what I wanted, ... umm ... I guess its about the possibilities that I never explored, I wondered what it would have been like if I hadn't terminated. I have a feeling that being a mother would have been a meaningful experience for me. Sometimes I also felt a little bit of anger for the way it all worked out.
>
> (Ferial)

... I felt angry ... with the person I was having a relationship with. Had the circumstances been different ... I wouldn't have minded having a child ... yes, I was angry, angry at myself for having got into a relationship like that in the first place ...

(Yumna)

I just stayed in my room most of the time, umm, because I felt low and down and depressed because it was like I was close to this child...

(Lindiwe)

Of note, are the various expressions of loss and sadness that appeared to underlie all of the internally based emotions that were reported by participants. These are illustrated in the following descriptions by Candice, Lindiwe and Ferial:

... it was a loss, an emptiness ...

(Candice)

... loss of a lot of things, loss of a baby, loss of a fantasy of something ... of a perceived connection, loss of trust in the relationship ...

(Candice)

... an abortion is not just about the termination of a foetus, it's often a termination of parts of yourself in a relationship ...

(Candice)

... I felt like there was a loss and I felt all this hurt inside me.

(Lindiwe)

A part of me feels like I gave up something that was a significant part of my life experience, a feeling like I could have had something.

(Ferial)

In addition to the important and often compelling reasons women have for wanting to terminate their pregnancies, there may be conscious or unconscious reasons for wanting to continue it. Although the present study did not investigate the intrapsychic meaning of abortion directly, it is clear that participants were at least somewhat ambivalent about terminating their pregnancies. It is also apparent that the experience of loss held many meanings for participants. The abortion appears to have been experienced as a final closing off of whatever positive potential the pregnancy may have held for the woman. This is distinctly portrayed in the following phrases; *loss of a baby, loss of a fantasy, loss of trust in the relationship, not just about the termination of a foetus, a termination of parts of yourself in a relationship, gave up something that was a significant part of my life experience, I could have had something.*

A detectible pattern in the present study was the indication that the women who had second-trimester abortions, Candice and Lindiwe, experienced a greater sense of loss and underwent a mourning process. Second-trimester pregnancies are associated with greater acknowledgement of the existence of a potential child (Adler et al., 1990). Candice and Lindiwe were also found to experience higher levels of ambivalence and some degree of coercion from their partners. The present investigation did not explore the dynamics between these factors in depth.

Nevertheless, it is suggested that Candice and Lindiwe delayed their abortion decisions because of ambivalence and that the final decision was informed to a greater extent by situational rather than personal reasons; in this case, coercion from the partner. Clearly, though, the inter-play between these factors merits further attention.

In addition, the abortion procedures involved in termination of second-trimester pregnancies were experienced by participants as physically and emotionally stressful. It is suggested that the procedures utilised in 'back street' settings, by their very nature, increase the risk of negative post-abortion physical and emotional sequelae. An investigation into the physical after-effects of illegal abortion is not within the scope of this study. With respect to its emotional impact, it appeared that the abortion procedure led to increased levels of generalised stress which, in turn, predisposed women for the experience of internally based emotions.

The increased levels of stress and distress experienced by Candice and Lindiwe were described as follows:

> ... it was extremely stressful ... I felt like it was all happening inside of me, and it was difficult to articulate ... why I was feeling this, this panic inside, this emptiness, this confusion.
>
> (Candice)

> I used to dream of a baby's hand on my cheek ... but I always woke up and sobbed because it was not there, it was gone.
>
> (Candice)

> I felt like there was a space inside of me that needed to be filled. That's why after having the abortion, I was like traumatised ...
>
> (Lindiwe)

In the above extracts, the words and phrases *emptiness, not there, space inside of me that needed to be filled* are all suggestive of the sense of void that resulted from termination of the pregnancy. These representations are congruent with the experience of loss reported by Candice and Lindiwe.

Furthermore, these descriptions serve to highlight the implications of abortion related grief. Firstly, women may not recognise their own grief since expectations are of relief from an untimely or undesired pregnancy. For Candice, this resulted in confusion. She explained her confusion as follows:

> ... I couldn't understand because there was supposed to be relief and I did not feel the relief ...
>
> (Candice)

Secondly, since post-abortion grief is not socially recognised, there is little acknowledgement of the sense of loss that has been incurred nor of the need to mourn this loss. Both personal and social sanctions against abortion may result in either women denying their grief or being unable to express it. Candice, who seemed to be in touch with her grief but unable to talk about it for fear of social disapproval, described her experience as follows:

... it was like having to mourn in a closet.

(Candice)

Speckard and Rue (1993) warned that if feelings of loss and grief are not acknowledged and resolved, complicated bereavement and depression may result. They recommended that women in this situation be given permission and encouragement to mourn the loss. Women in this study attended to their grief through personally meaningful processes. Candice shared that:

> ... a lot of my expression is quite private ... I've held on to things that remind me of the experience ... I have taken on some private rituals around it, to help me mourn.

(Candice)

Lindiwe related that:

> I gave my child a name. It was a way of accepting what happened, umm, and my feelings and dealing with it.

(Lindiwe)

Both Candice and Lindiwe utilised psychotherapy to support them through the grief process:

> I then made arrangements to get ... into therapy.

(Candice)

... it was very difficult for me so I went to see a counsellor to talk about it.

(Lindiwe)

As already mentioned, the role of counselling in women's post-abortion adjustment will be scrutinised later in the analysis. To conclude the section on women's post-abortion psychological responses, it is suggested that the abortion experience varies in the amount and kinds of stress it produces for the woman. Findings indicated that decision difficulty, discussed in an earlier section, is significantly related to internally based emotions, but less so to socially based emotions or to positive emotions experienced afterwards. Furthermore, decision difficulty was related to ambivalence, meaningfulness of the pregnancy, coercion from the partner and termination of second-trimester pregnancy. Decision difficulty together with the circumstances surrounding illegally induced abortion were, thus, found to be related to poor post-abortion adjustment.

Adjustment to abortion also appeared to be related to participants' social support and self-efficacy for coping with the abortion. These factors will be considered next.

4.3.5 Coping with the Abortion

Over the past two decades, social science researchers have devoted increasing attention to the ways in which people cope with stressful or negative life events and to factors that predict and enhance coping. In recent years, a number of researchers have investigated abortion within this framework, more specifically, the stress and coping model (Major & Cozzarelli, 1992). As reported in Chapter Two, the present study was informed by this theoretical trend.

Findings from this study indicated that perceived social support, self-efficacy for coping with the abortion and adequate coping abilities had a positive effect on women's post-abortion adjustment. These factors are considered below.

Studies that have examined the relationship between perceived social support and women's adjustment to abortion are consistent in indicating that perceived support is an important factor in women's post-abortion adjustment (Major et al., 1990). In this study, perceived support from the partner relationship was found to be strongly related to participants' post-abortion adjustment. It appeared that having a positive relationship with the partner, perceiving a high level of support from the partner and feeling that one can depend on the partner in the future were all related to better pre- and post-abortion coping. Support from friends and family did not emerge as an influential factor in women's post-abortion adjustment.

The following extracts present women's perceptions of the influence of partner support:

> His presence was very important to me. I needed him to be there for me, umm, to support me through this stressful time. I had supportive friends, but it's not the same as having your partner there with you, it makes you feel like you can do this and you'll be fine.
>
> (Ferial)

We have a good relationship, so he was very supportive. We talked and he was prepared to go with whatever I wanted ... I knew that I could depend on him and that gave me strength.

(Portia)

Undoubtedly, the male partner is a potentially crucial factor in women's adjustment to abortion. Major and Cozzarelli (1992) concluded that women who make the decision to have an abortion alone present with poorer post-abortion adjustment than those who receive support from their partners. Candice, Lindiwe and Yumna described the lack of support from this source as follows:

... what freaked me out was that I was feeling all this confusion, things I couldn't talk about, that I couldn't make sense of, and it felt like he got on with his life...

(Candice)

What was so difficult was that it was like nothing happened for him. He got involved with someone else and I would see them together and I had to go through everything on my own.

(Lindiwe)

... he wasn't very supportive ... blamed me for what had happened ...

(Yumna)

Given that a range of factors appear to influence women's post-abortion adjustment, it is difficult to establish the extent to which lack of support resulted in negative post-abortion sequelae. However, it is evident that perceived social support is related to self-efficacy for coping with the abortion. This is illustrated in the following phrases; *I could depend on him and that gave me strength, it makes you feel like you can do this and you'll be fine*. Major et al. (1990) established that the relationship between perceived social support and adjustment is not direct, but operates through increasing perceived coping self-efficacy.

The present inquiry also found that for three women coping self-efficacy was more dependent on personal rather than situational resources. Cozzarelli (1993) found that personality variables such as locus of control, optimism and high self-esteem increase self-efficacy for coping. Although the present investigation did not determine specific dispositional factors related to better post-abortion coping, it appeared as if personal resources operated as stress resistance aids by fostering positive beliefs about women's ability to cope with the abortion. This is illustrated in the following descriptions by Ferial, Portia, Candice and Yumna:

> Mostly, I knew, I know that I am resilient. Yes, I had some feelings about the abortion, and I felt that I had to look at these feelings, work through them and move on as best as I could.
>
> (Ferial)

> I think I'm a tough kind of person, strong and that helps me to deal with problems.
>
> (Portia)

> I thought that I was going to get on with my life ... so some of that worked out well.
>
> (Candice)

> I am a strong person ... I think that I deal quite well with things, umm ... when things go wrong or if I'm feeling stressed or something, I always do something about it.
>
> (Yumna)

The consistent references to emotional strength, as illustrated by the words *resilient, strong, tough*, stand out in the above extracts. It is speculated that these characterisations were enhanced by the women in their interpretations of how they coped only in the retrospective context of the abortion experience. This may be seen to serve an adaptive coping function in that it may have strengthened women's beliefs in their ability to cope with the abortion. Past research has examined women's self-efficacy for coping with abortion primarily in the pre-abortion context. In the present study, however, none of the women referred to pre-abortion self-efficacy for coping with the abortion. It is, therefore, suggested that post-abortion self-efficacy for coping with abortion may also play an important role in women's post-abortion adjustment.

The above reflections also highlight participants' coping styles. The descriptions, *look at these feelings, work through them, always do something about it*, suggest the use of active approach and problem-focused coping styles. The following quotation typifies some of the features of an active approach coping style:

... talking about it ... I think about it often, I read about it, so psychologically, I have some idea what happens, that helps.

(Candice)

Cohen and Roth (cited in Major & Cozzarelli, 1992) established that in talking and thinking about their experiences, women tend to enhance their post-abortion adjustment. Portia's and Yumna's experiences appeared to confirm this:

... what helped was being able to talk about it to him [boyfriend]. I think that really helped. Not to keep it all bottled up inside of me but to share it with someone ... yes, that's how I coped with the abortion.

(Portia)

Talking to the friend about it helped but also by thinking, rationalising about it in my mind, that I did it for myself and the right reason and that I wasn't forced into it.

(Yumna)

Rationalising about it appeared to have been a coping strategy used by other participants as well. Portia and Lindiwe shared:

... I'm living with it ... it's fine for me. It's what I wanted for myself, so I made the right decision, umm, that's how it feels for me.

(Portia)

Whatever happened is in the past ... I just have to move on.

(Lindiwe)

... when I look back I just feel that it was the best that I had the abortion because it would have been very difficult for me to raise a child.

(Lindiwe)

Whilst Portia and Lindiwe reported that interpreting their abortion experiences in this manner helped them to cope, it is possible that rationalisation may have also concealed more difficult feelings around the abortion. It is acknowledged, however, that even if this were the case, defensive coping strategies such as rationalisation may be adaptive during the early stages of coping with a stressful event since an individual may not have the resources to confront difficult feelings then. Accordingly, such a coping strategy may be seen to reduce immediate stress.

In contrast, avoidance and denial was seen to predispose Lindiwe to poor post-abortion adjustment. She depicted her maladaptive coping style as follows:

I suppressed all the hurt, I didn't want to think about it ... I threw myself into my studies. When I saw the counsellor, I realised that I hadn't been dealing with my feelings properly.

(Lindiwe)

It is proposed, then, that women who (a) exert more effort in coping situations, (b) have a wider repertoire of coping resources at their disposal and (c) make use of more successful coping

strategies are at reduced risk for negative post-abortion consequences. This is also the case for women who seek more or make better use of social support. Therefore, social support, especially from the male partner, may be critical in helping women overcome the negative effects of abortion related stress. This is underscored by the fact that strong moral sanctions in South African society against both pregnancy in unmarried women and abortion often contribute to women experiencing conflicting emotions about their decision and negative reactions from friends or family members.

In terms of the theoretical model within which the present study was located, that is, the stress and coping perspective, abortion may be seen as an event that can be challenging or stressful. The stress engendered by the unwanted pregnancy may be reduced by termination of the pregnancy. At the same time, the abortion itself may be experienced as stressful by the woman. The circumstances surrounding abortion, such as the actual experience she has in procuring the abortion or support for abortion by her partner, in conjunction with the woman's psychological and social resources, provide the context that will affect a woman's responses to the abortion.

Within the framework of stress and coping theory, the above discussion may also be observed to highlight such questions as how poor adjustment can be prevented and how it can be improved. Accordingly, these concerns have implications for abortion counselling. These will be reviewed in the final section of the report.

4.3.6 Counselling Needs Identified

Researchers have emphasised that pre- and post-abortion counselling interventions are valuable in reducing the prevalence of negative post-abortion responses. Abortion counselling offers women the opportunity to deal with the stress of unwanted pregnancy and abortion within a supportive milieu. However, none of the participants in the present study received either pre- or post- abortion counselling. This may be reflective of the experiences of a large majority of South African women who undergo illegal abortions. The settings that typically characterise illegal abortion, by their very nature, fail to offer such interventions. In this regard, participants agreed that counselling interventions may be of potential benefit to women in similar situations. Candice and Ferial appeared to have granted in-depth consideration to the issue of abortion counselling. They offered the following general recommendations for abortion counselling:

> I just also want to say, I'm for the [new] legislation on abortion, but I have difficulty with it not being paired with counselling ... allow women to feel and work through before they make the decision. Even though this experience does not jeopardise your mental health, it causes strain ... so there must be some model for providing support to women.
>
> (Candice)

... abortion counselling is so vital. An objective presence, someone who understands what it's like for the woman, both emotionally and physically ... there must be space for the woman to say what it's like even it seems unimportant at the time, 'cos if you don't listen to it, you don't acknowledge it...

(Candice)

... and to understand why it happened, because of contraceptive failure or because of an unconscious connection or fantasy ...

(Candice)

If you don't look at it, there may be effects to look at later.

(Candice)

I think that counselling is crucial, umm, to help the woman to assess if she is making the correct decision, and if she is, to prepare her for it and to look at ways to help her cope with the experience.

(Ferial)

... I think that women should be given the option ... they can choose if they want to use the option, but they should be encouraged to because it can only help, especially for those women who don't have support. Also, if the woman is uncertain and confused or if she has mixed feelings about what she wants. I think then pre-abortion counselling can be very useful in clarifying things for so that she doesn't feel afterwards like she took the wrong decision. (Ferial)

The above descriptions demonstrate a high level of awareness and insight around the issues facing women who are dealing with unwanted pregnancy and abortion and illuminate the needs of women in this situation. In this regard, the Select Committee on Abortion and Sterilisation recommended that counselling be made available to all women requesting abortion and that it be non-mandatory in the case of adult women (Dyer, 1995). Specifically, women seeking an abortion require an empathic reception from abortion counsellors who, furthermore, refrain from imposing their own sexual and moral standards on women seeking abortion. Most researchers have concluded that counsellors need not be medically trained and that obligatory psychiatric referral is undesirable except in cases where the woman has a serious psychiatric illness (Romans-Clarkson, 1989). Nonetheless, it is apparent that counselling could be useful in resolving ambivalence towards the abortion. In support of this, Candice stated:

> If I had some pre-abortion counselling, and had some opportunity to talk through it honestly and rationally with the person I was involved with, I would not have felt as much confusion, as much ambivalence, during and after. Umm ... I think I would have been able to come up with a clearer decision, to have the baby or not to have the baby. I feel I didn't do that for myself, there was no space to do it.
>
> (Candice)

> As far as possible, I would like to see the couple committing themselves to that process. I think it's so important, it helps you to separate things from the relationship ... to see what it means to have a baby, what it means to be a single

parent, to have the baby within the relationship, and to be under no illusions about anything, so talking through and being extremely honest with each other...

(Candice)

The above descriptions also attest to the significant influence that the male partner was found to have on women's decision-making process and subsequent adjustment to abortion. In response to this finding, researchers and clinicians have suggested that abortion counsellors assist a woman to examine her relationship with her partner if it appears that she is appreciably less motivated for the abortion than he is and/or is acquiescing to his wishes, or if she wants to have the child but that problems with her partner make the timing bad (Miller, 1992). However, this need not necessarily be undertaken within the context of couple counselling. Cozzarelli et al. (1994) advised that counselling be undertaken with reference to the specific characteristics and needs of the woman involved.

In relation to their needs around post-abortion support, participants expressed varying sentiments. Yumna, who reported minimal decision-making conflict, did not feel the need to explore her post-abortion experiences, but wished to get on with her life:

I feel mostly ok about the abortion. It didn't scar me in any way, so that's that.

(Yumna)

Candice expressed different needs:

I think what would have been helpful for me ... to keep the issue current, not to let it go away because now your studies are on track, you're in another relationship, but to talk about it. Maybe a support group with other women ... later on have these options where women can contact people who can provide the service...

(Candice)

... when you're still agonizing about it a few months later, it would be nice to talk to other women, to listen to other experiences.

(Candice)

Ferial also supported the need for post-abortion counselling:

It can help women to deal with their feelings in a healthy way. Some women ignore difficult feelings, but it inevitably catches up with them. So to improve their emotional state, umm ... it can be helpful.

(Ferial)

However, unlike Candice, she believed that a support group would not have suited her own post-abortion support needs. Nonetheless, she acknowledged it's potential value:

... it [support group] may not work for all women. I don't think I would be too comfortable in a group set up, but that's me. Other women may prefer it, so it's

an individual thing. The point is, there should be those kinds of options anyway.

(Ferial)

The above extracts demonstrate the overall stressful nature of abortion and the need to *talk about it* afterwards. Lemkau (1988) asserted that retrospective reconstruction of the abortion experience, through psychotherapeutic interventions, provides women with the opportunity to verbalise their feelings and deal with negative post-abortion consequences. In this sense, support groups invite women to share common experiences, offer group members the opportunity to learn from each other's experiences and include the potential benefit of engendering a sense of self-empowerment, especially in the case of self-help groups. McCulloch (1996) suggested that group work may also be a more accessible alternative to individual counselling.

Some clinicians have concluded that, whatever the context, healing can result from simply providing support and bearing witness to a woman as she shares the story of difficult and irrevocable decisions she has made. Lindiwe, who underwent individual counselling after the abortion supported this idea. She described her experience as follows:

It was good. She [counsellor] was the only person I could talk to, I could tell her everything I was experiencing. (Lindiwe)

... it helps when someone else understands what you're going through, what you're feeling ...

(Lindiwe)

Lindiwe found that her counselling sessions enabled her to gain insight into her abortion decision which, in turn, appeared to facilitate her post-abortion adjustment. She explained:

> ... when I went to counselling, she [counsellor] actually helped me to see ... I could just see the importance of the child in my life, and that is probably why I had mixed feelings. When I think of it now ... maybe I wanted a child ... I just felt that I could have related to my child, just watching the child grow. And that's why I felt sad after the abortion, you know, like I lost something. I gave my child a name. It was a way of accepting what happened, umm, and my feelings and dealing with it.
>
> (Lindiwe)

Candice was the other women in the present study who sought individual counselling. Unlike Lindiwe, she consulted a male counsellor. Her experience of counselling differed from Lindiwe's. She described her experience as follows:

> ... he [counsellor] did his best to understand, but I don't think he really understood. I couldn't help but think that if I had a woman therapist ... it would have been a difference experience.
>
> (Candice)

The above extract raises the issue of gender in abortion counselling. To date, a gendered approach to abortion counselling has received minimal attention in abortion research. The idea

that women like Candice may prefer to be seen by a woman counsellor suggests that this area of abortion counselling warrants further consideration.

The possible liberalisation of abortion laws makes it necessary for the national health service to address women's pre- and post-abortion support needs. Presently, women undergoing illegal abortion have minimal access to counselling services. The women in this study who utilised psychotherapy in dealing with their post-abortion feelings did so through private psychological services, which are known to be inaccessible to the majority of black South African women. Clearly, then, abortion counselling services should be organised as an integral part of the national health service and not as a separate system. A detailed discussion of the implications of these and other findings is presented in the next chapter.

4.3.7 Women's Responses After the Interview

Finally, the impact of the interviewing situation on women's experiences is considered. The researcher shared Bannister's (1994) concern that the changes to which the research is directed may well be worthy, but may be of no immediate benefit to the participant 'whose experience is subordinated to a preconceived or more or less imposed interpretive framework' (p. 53). Accordingly, the influence of the interviewing experience on participants' responses were explored immediately after the interview and, in one case, during follow-up contact with the participant.

Participants' responses immediately after the interview were generally positive. Candice and Yumna shared that talking about the abortion experience had been cathartic:

> I find this kind of expression healthy for myself ... emotionally it gave some space for ventilation. It was fine to talk about it, I didn't feel any pressure from you, I had the space to talk about it in a way that felt fine for me.
>
> (Candice)

> ... that I can talk about it and getting it off my chest ...
>
> (Yumna)

The therapeutic value of *ventilation, getting it off my chest* is illustrated in the above extracts. As already mentioned, bearing witness to a woman as she shares her story may be an extremely healing experience for her. Moreover, it is hypothesised that the open-ended interviewing style that was employed allowed Candice to share her experience on her own terms, illustrated by the phrases *I didn't feel any pressure from you, I had the space to talk about it in a way that felt fine for me*. It is suggested that a research relationship that allows participants a degree of choice and autonomy in relation to the research query may be empowering for them.

Ferial, on the other hand, appeared guarded about the impact of the interview on her feelings about the abortion. She said:

> I found it, er, useful to talk about this because it gave me an opportunity to reflect on things for myself. (Ferial)

She did not elaborate on her reflections. It is unclear as to whether the interview raised feelings around the abortion that she did not feel comfortable to share.

Another aspect of the interviewing situation that participants highlighted was the experience of having entrusted the researcher with their stories. Yumna and Portia reported the following:

> ... and telling someone else other than the only person who knows ... my friend.
>
> (Yumna)

> You're the only other person, besides my boyfriend, that knows about it now.
>
> (Portia)

For the researcher, the above descriptions accentuated the perception that the research enterprise was a shared experience, based on mutual trust. The above quotations also suggest that the interview allowed participants to break the silence over what is clearly a socially taboo subject. In this regard, Candice expressed:

> ... I think that by doing some of this it validates my experience. It makes it feel less of a closet experience ...
>
> (Candice)

Participants also expressed satisfaction that they were able to contribute to the research endeavour. Furthermore, they communicated the desire that sharing their own experiences would have a positive influence on the social and personal positions of other South African women. Yumna, Ferial and Candice verbalised the following sentiments:

I think to be able to help your thesis ... would make a difference in some way. I hope that it does, who knows maybe it will make a difference in the present legislation or the one that's to come ... I'd like it to make a difference to other women and hope that it does.

(Yumna)

...I'm pleased that I could assist in your research, I hope it's going to make things better for the women of this country ...

(Ferial)

I'm also invested in research in areas concerning women, so I feel like this is something I want to do, and I need to do.

(Candice)

It is suggested that the above depictions illustrate a position of empowerment and social consciousness. It has been previously documented that through participation in research that allows for silences to be uncovered, women may come to feel more empowered about their personal and social positions in society (Olesen, 1994). However, with respect to women in the present study, it was not possible to predict whether the above-mentioned influence would persist beyond the interviewing situation. Nonetheless, the researcher was generally satisfied with participants' reflections on the interview process.

In exploring the impact of the interviewing situation on participants' experiences, it was evident that Lindiwe was uncertain and preferred not to reflect on it. The researcher was aware that

the interview had re-evoked difficult feelings for her and offered her the option of post-interview counselling, which she declined. Nevertheless, the researcher contacted her again to inquire how she was feeling. Lindiwe shared that the interview had prompted her to reflect deeply about the extent to which she had resolved her feelings of loss around the abortion. She recognised that she still felt a great deal of sadness, but claimed that she was able to cope with her feelings without psychotherapeutic support. Although she appeared to be confident about her own coping ability, the researcher invited Lindiwe contact her in the event that her needs changed and she wished to pursue the counselling option.

When the researcher returned to participants with her findings, she did not observe any further indications of the impact of the interviewing situation on the women. However, it is acknowledged that the researcher did not make any direct inquiry in this regard. With respect to the findings of the current study, the analysis that has been presented in this chapter will be integrated in the next and final chapter of this thesis.

CHAPTER FIVE

CONCLUSION

5.1 Introduction

This chapter aims to summarise the major findings of the study and to explore their significance in terms of abortion policy and counselling interventions. Additionally, the limitations of the present study, as well as recommendations for future research, are presented.

5.2 Summary of Research Findings

This research presents five women's voices as they described the abortion experience and the factors that influenced their short-term post-abortion adjustment. The study confirmed the complexity of the abortion experience and revealed that it varies in the amount and type of stress it generates for the woman. The present inquiry accentuated the fact that women's post-abortion responses are not determined by only one factor or type of factor. Instead, the manner in which women responded to the procedure was found to be a joint function of their psychological state and of the social environment in which the abortion occurred.

The study affirmed that the abortion decision is multi-dimensional. Women of diverse developmental levels, with different personal roles and responsibilities and from varying socio-economic circumstances were found to use abortion to avoid unwanted child-bearing. Women who are socially or economically disadvantaged because of 'minority' or economic status were

over-represented among the women that participated in the study. It was established that women's decision to abort was related to internal, personal characteristics (e.g., their needs, immaturity), as well as to external circumstances (e.g., educational, career, economic status, relationships with others) which were particularly salient. These findings support previous outcomes which have concluded that women's abortion decisions reflect their desire to optimise the quality of their lives and to reduce the risk of psychological, social and economic disadvantage for themselves (Adler et al., 1990; Russo et al., 1992).

However, whilst most of the women in the study did not report severe distress or psychopathology following the abortion, some negative experiences were recorded. Various aspects of the abortion experience contributed to negative post-abortion responses. The extent to which the women experienced decision difficulty, the nature of the social environment surrounding the abortion process and the woman's coping responses were found to be related to her post-abortion adjustment.

Participants' descriptions reflected that the greater the difficulty of deciding to terminate a pregnancy, the more likely there will be negative responses after abortion. The decision to abort appeared to have been more difficult for the women who terminated second-trimester pregnancies. In addition, women who were highly ambivalent about the abortion decision reported the experience to be more stressful. Ambivalence, in turn, was related to women's interpretations of the meaning of the pregnancy; the extent of 'wantedness' of the pregnancy, what it represented to the woman and what her feelings were about the pregnancy and its termination. As Adler et al. (1992) proposed, the more a pregnancy is wanted and is interpreted as personally meaningful by the woman, the more difficult abortion may be. These factors were

also perceived to contribute to delay in obtaining abortions, subjecting women to the greater stress of second-trimester procedures. It is, therefore, suggested that women who report little difficulty in making the abortion decision, who are more satisfied with their choice and who terminate pregnancies that are unintended and unwanted and hold little personal meaning for them demonstrate more positive responses after abortion. These findings replicated those of previous research (Major & Cozzarelli, 1992).

Furthermore, the influence of the socio-cultural milieu in which induced abortion occurs was experienced by participants as counteractive to eliciting social support from significant others, such as family members. This was viewed as being disadvantageous to the woman given that both perceived and actual support can act to buffer some adverse psychological effects of stressful life events (Major et al., 1990). In South Africa, like in many other societies, the dominant social discourse on abortion is prohibitive. The social stigma that this has engendered has resulted in the silence of participants around their abortion experiences and negative, socially based post-abortion emotions.

As the literature on social support has also illustrated, the male partner is an influential factor in women's adjustment to abortion (Cozzarelli, 1994; Major et al., 1992). This was validated by findings from the present study. It was found that coercion from the male partner may serve as a 'risk' factor for the experience of deleterious post-abortion responses. This observation was supported by women's interpretations of satisfaction with the abortion decision. It was established that women whose motivations for abortion were internally based and who, therefore considered their decisions to be personally meaningful, coped better with the abortion and

suffered minimal negative post-abortion effects as compared to women who were influenced by external factors, such as coercion, to terminate their pregnancies.

The social climate surrounding the abortion experience and its influence on women's adjustment was also related to the abortion setting itself. The present inquiry challenged the supposition that emotional risks do not vary in accordance with the legislative restrictions on abortion (Ney & Wickett, 1989). Findings from the present study contradicted the outcome of McCulloch's (1996) investigation into induced abortion in South Africa. Her analysis reported no differences between women undergoing legal and illegal abortion. Firstly, social constructions of 'back street' abortion engender a sense of criminality. Secondly, 'back street' abortions are sometimes procured under difficult circumstances and performed under unsafe conditions. Thirdly, these settings are generally not set up to provide interventions in response to the stress-related and coping needs of women. These factors were illustrated to increase stress and undermine women's coping responses to abortion, thereby increasing the risk for the experience of poor post-abortion adjustment. In comparison, the more favourable social environment associated with legal abortion has been found to minimise women's vulnerability for the experience of poor post-abortion adjustment.

In terms of coping responses, participants' descriptions revealed that they were inclined to deal with the abortion experience in terms of their usual defensive and coping strategies. Predictably, women with more adequate coping abilities were predisposed to better post-abortion adjustment. In addition, post-abortion self-efficacy for coping was found to have a positive influence on participants' coping repertoires. Past research has focused primarily on pre-abortion self-efficacy for coping. Based on participants' accounts, it was also evident that, had

they been available, pre- and post-abortion counselling interventions may have been valuable in assisting women with both the abortion decision as well as the post-abortion experience.

The preceding discussion, then, represents five women's experiences of induced abortion. Therefore, no attempt is made to generalise the findings of the present study. In conclusion of the above summary, it is reiterated that the qualitative mode of inquiry was found to be most meaningful in exploring women's experiences of abortion. It allowed for the uncovering of complexity and nuance, it allowed participants to reclaim their voices and, most importantly, it honoured lay-peoples' interpretation of social reality. It is also recognised that the findings reported here only begin to explore black South African women's experiences of induced abortion. However, these issues are likely to become of increased importance as the South African legislative assembly deliberates on the country's public policy on abortion. Accordingly, the implications of these findings deserve attention.

5.3 Significance of Research Findings

The findings summarised here have a number of implications for both public policy and clinical practice on abortion.

Recently there have been increasing calls for non-restrictive legislation on abortion. The anti-choice lobby, in turn, has cited the supposed prevalence of severe psychopathology in women undergoing abortion as an argument against the liberalisation of abortion laws. Although the findings of the current study can be considered only preliminary and can only suggest future trends, participants' accounts of their abortion experiences suggests that abortion is not

experienced as particularly traumatic by the majority of women in the short-term period following abortion. Furthermore, the findings also suggest that as long as women have unintended and unwanted pregnancies, and as long as abortion is viewed as a way of resolving the problems such pregnancies generate, then women will continue to access 'back street' abortion services. These considerations suggest that if the availability of abortion was to become less restrictive, this process would probably reduce the risk for poor post-abortion adjustment rather than increase it, as has often been argued by anti-choice activists. Findings such as these could, therefore, inform policy-makers about the relationship between abortion and mental health.

The factors that were found to be related to negative post-abortion responses also have implications for pre- and post-abortion counselling programmes. First, they suggest that it may be possible to identify women, prior to their abortions, who may be at risk for affective problems shortly after the abortion. Second, they suggest that it is possible to design counselling interventions that facilitate women's adjustment to abortion. Thus, it appears feasible, through counselling services, to reduce the prevalence of negative post-abortion effects. For example, interventions that assist the woman to focus on and clarify the meaning of the pregnancy for herself and to own her decision may be critical in pre-abortion counselling. In addition, post-abortion counselling interventions that enhance the woman's self-efficacy for coping with the abortion may favour better post-abortion adjustment. The factors related to negative post-abortion responses may also assist counsellors to understand and address those aspects of the abortion experience that women have difficulty resolving. Moreover, the outcomes reported here suggest that counselling programmes provide further information about contraception and focus on women's post-abortion contraceptive practice. Finally, it is

recognised that an effective abortion programme cannot be designed without a reliable general health service. Clearly, then, the challenge for social science researchers is to advance inquiry in the area of abortion so that outcomes may impact on policy and service delivery in a way that enhances women's well-being. Consequently, social science researchers have important roles to play in helping women communicate their realities.

5.4 Limitations of the Study

The limitations that are identified relate to both the research paradigm that was favoured as well as to the actual field of investigation.

The qualitative research paradigm was considered to be the most appropriate model to offer a social psychological level of analysis. However, the spread and depth of participants' descriptions involved time-consuming and labour-intensive analytic processes. Moreover, in the final analysis, the range of descriptions that emerged in the study was restricted to the scope of the investigation and, therefore, involved selective analysis of the constructive aspects of social actors' lives. This factor, together with the consideration that the researcher's interpretations are subjective, implies that research of this nature is never completely exhaustive and that participants' social constructions may be further analysed by other researchers (Bannister, 1994).

With respect to the field of inquiry itself, it was found that women in the target group were reticent to participate in the study. This, in turn, delayed completion of the study. It is hypothesised that this was due to the sensitivity of the research area. The politically charged

climate surrounding abortion, social and moral sanctions against it and the criminal status of 'back street' abortion have clearly forced many women into silence.

As alluded to already, the investigation neither explored nor analysed the abortion experience in all its complexity. It focused primarily on participants' psycho-social experience of abortion. However, it is apparent that women's experiences of abortion encompass a range of influences and therefore need to be understood within this multi-faceted context. This consideration has implications for future research, to be discussed hereafter.

5.5 Recommendations for Future Research

In the previous chapter, several references were made to directions for future research. These are reflected in the following discussion, which aims to present the principal indicators for future research in the area of abortion.

Firstly, more research efforts are needed in order to confirm the themes identified in this study and to test their clinical utility with women from a wide range of cultural, ethnic, socio-economic and geographical backgrounds. Further research will also increase the repertoire of knowledge on women's abortion experiences, illuminating factors not explored in the present study, such as the impact of abortion on women's bodies and sexuality. These findings will inform counselling interventions aimed at minimising the risk of negative post-abortion sequelae. In the face of imminent legislation reform, such inquiry is imperative.

Secondly, a full description of adjustment to abortion will not be achieved until a longer term study can be conducted. For example, intervening fertility-related events, such as having another abortion, giving birth or the death of a child, might prompt a woman to reconstruct the meaning of her abortion and might engender more positive or negative feelings about having had the abortion. Given that researchers and clinicians have not identified any 'critical stage' in relation to adjustment to abortion, a more informative study would interview women frequently over the course of several years. A study of this nature would also need to undertake an in-depth analysis of the social texts emerging from women's descriptions of their abortion experiences.

Thirdly, more information is needed about the interactive influence of partners and family members on women's efforts to cope with unwanted pregnancy and abortion. A notable limitation of this study and existing literature is the lack of information from male partners about their responses to unwanted pregnancy and abortion. They, undoubtedly, have their own stories to tell.

Several other areas remain to be explored more fully in future research. For example, research needs to focus on interventions that address issues around contraception, given that findings indicate that contraceptive failure and non-use may contribute to the use of induced abortion as an alternative to unwanted pregnancy.

In addition, it would be instructive to explore the effects of treatment by health care staff participating in abortions on women's post-abortion responses. The findings may be integrated into interventions aimed at minimising the risk for deleterious post-abortion consequences and

may also inform support interventions for staff who may be disturbed by their participation in abortion procedures. This is especially important since the liberalisation of abortion legislation would imply increased participation in abortion procedures for health care providers.

Finally, a pressing research agenda for the future is to examine and compare women's adjustment to the alternatives to unwanted pregnancy, that is, to terminate the pregnancy, to place the child for adoption or to have the baby. It is believed that only then can psychological responses to abortion be located within their appropriate context.

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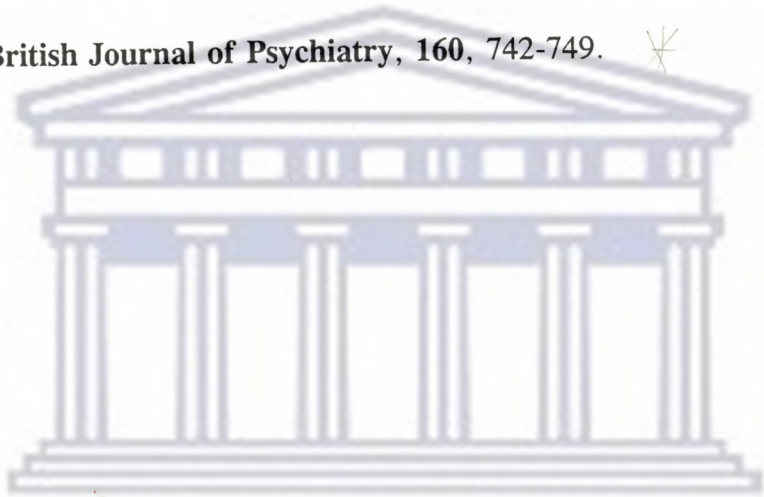

APPENDIX A

Unstructured Interview Topic Guide

1. Socio-Demographic and Biographical Details

Age

Residence (area), resides with whom

Marital status

Number of previous pregnancies

Number of children

Years of schooling

Occupation

Religious preference

Psychiatric History

2. Circumstances Regarding the Pregnancy

Contraception

Motivation for pregnancy

Feelings about pregnancy once you knew about it

Attributions for the pregnancy

Relationship history/partner details

Personal attitudes regarding pregnancy and abortion

Psychological functioning prior to discovery of pregnancy

3. Decision-Making Process

When did you make the decision

Factors influencing decision to terminate pregnancy (e.g.

socio-economic circumstances, relationship status, social coercion)

Personal conflict (e.g. religious, intended pregnancy/ambivalence)

Social conflict (e.g. stigma)

Role of partner

Seeking information/support (e.g. pre-abortion counselling)

4. Abortion Procedure

Access, process of obtaining abortion

When, who performed, what method, setting

How did you feel

5. Coping Responses

General coping style

Coping expectancies

Personal resources and social support

Influence of partner's responses on woman's own coping responses

6. Outcomes

Emotions - positive and negative

Post-abortion difficulties

General functioning, and life events subsequent to abortion

Impact of abortion on different aspects of woman's life

7. General

Reasons for participation in the study

How do you feel about having shared your experience with me

What would help women in similar situations, why

APPENDIX B

ABORTION AND STERILISATION ACT NO.2 OF 1975

ABORTION AND STERILIZATION ACT NO. 2 OF 1975

[ASSENTED TO 28 FEBRUARY, 1975] [DATE OF COMMENCEMENT: 12 MARCH, 1975]

(*English text signed by the State President*)

as amended by

Abortion and Sterilization Amendment Act, No. 18 of 1976
Abortion and Sterilization Amendment Act, No. 38 of 1980
Abortion and Sterilization Amendment Act, No. 48 of 1982
Abolition of Racially Based Land Measures Act, No. 108 of 1991
[with effect from 1 April 1992—see title LAND]

ACT

To define the circumstances in which an abortion may be procured on a woman or in which a person who is incapable of consenting or incompetent to consent to sterilization, may be sterilized; and to provide for incidental matters.

1. **Definitions.**—In this Act, unless the context otherwise indicates—

"**abortion**" means the abortion of a live foetus of a woman with intent to kill such foetus;

"**Director-General**" means the Director-General: Health and Welfare;

[Definition of "Director-General" inserted by s. 1 (*a*) of Act No. 48 of 1982.]

"**incest**" means carnal intercourse between two persons who are related to each other and by reason of such relationship incompetent to marry each other;

"**magistrate**" includes an additional and an assistant magistrate;

"**medical practitioner**" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974);

"**Minister**" means the Minister of Health and Welfare;

[Definition of "Minister" substituted by s. 1 (b) of Act No. 48 of 1982.]

"**prescribed**" means prescribed by regulation made under this Act;

"**psychiatrist**" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974;

"**State-controlled institution**" means a hospital conducted by the State (including a provincial administration), and such part of any other institution, other than such a hospital, as may be hired and controlled by a provincial administration;

[Definition of "State-controlled institution" substituted by s. 35 of Act No. 108 of 1991.]

"**sterilization**" means a surgical operation performed for the purpose of making the person on whom it is performed incapable of procreation, but does not include the removal of any gonad;

[Definition of "sterilization" substituted by s. 1 (c) of Act No. 48 of 1982.]

"**unlawful carnal intercourse**" means rape and incest.

[Definition of "unlawful carnal intercourse" substituted by s. 1 (d) of Act No. 48 of 1982.]

2. **Prohibition of abortion.**—No person shall procure an abortion otherwise than in accordance with the provisions of this Act.

3. **Circumstances in which abortion may be procured.**—(1) Abortion may be procured by a medical practitioner only, and then only—

(a) where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health, and two other medical

practitioners have certified in writing that, in their opinion, the continued pregnancy so endangers the life of the woman concerned or so constitutes a serious threat to her physical health and abortion is necessary to ensure the life or physical health of the woman;

(*b*) where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy creates the danger of permanent damage to the woman's mental health and abortion is necessary to ensure the mental health of the woman;

(*c*) where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped, and two other medical practitioners have certified in writing that, in their opinion, there exists, on scientific grounds, such a risk; or

(*d*) where the foetus is alleged to have been conceived in consequence of unlawful carnal intercourse, and two other medical practitioners have certified in writing after such interrogation of the woman concerned as they or any of them may have considered necessary, that in their opinion the pregnancy is due to the alleged unlawful carnal intercourse; or

[Para. (*d*) substituted by s. 2 (*b*) of Act No. 48 of 1982.]

(*e*) where the foetus has been conceived in consequence of illegitimate carnal intercourse, and two other medical practitioners have certified in writing that the woman concerned is due to a permanent mental handicap or defect unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus.

[Para. (*e*) added by s. 2 (*c*) of Act No. 48 of 1982.]

(2) (*a*) A medical practitioner who has issued a certificate referred to in subsection (1) shall in no way participate in or assist with the abortion in question, and such a certificate, or such certificates issued for the same purpose, shall not be valid if issued by members of the same partnership or by persons in the employ of the same employer.

(*b*) The provisions of paragraph (*a*) shall not apply to the performance by any person of his functions in the service of the State.

(3) At least one of the two medical practitioners referred to in subsection (1)—

(*a*) shall have practised as a medical practitioner for four years or more since the date of his registration as a medical practitioner in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974);

(*b*) shall be a psychiatrist employed by the State, if the abortion is to be procured by virtue of the provisions of subsection (1) (*b*);

(*c*) shall be the district surgeon who examined the woman concerned if a complaint regarding the alleged unlawful carnal intercourse has been lodged with the Police, and the foetus is alleged to have been conceived in consequence of such unlawful carnal intercourse.

[Para. (*c*) substituted by s. 2 (*d*) of Act No. 48 of 1982.]

4. Sterilization of persons incapable of consenting thereto.—(1) A sterilization shall not be performed on any person who for any reason is incapable of consenting or incompetent to consent thereto, unless—

(*a*) two medical practitioners, of whom one shall be a psychiatrist, have certified in writing that the person concerned—

(i) is suffering from a hereditary condition of such a nature that if he or she were to procreate a child, such child would suffer from a physical or mental defect of such a nature that it would be seriously handicapped; or

(ii) due to a permanent mental handicap or defect is unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus;

[Para. (*a*) amended by s. 3 of Act No. 48 of 1982.]

(*b*) the person who may in law consent to an operation beneficial to that person has granted written consent to the sterilization or, if there is no such first-

mentioned person or such person cannot after reasonable inquiry be found, the magistrate of the district in which the person concerned finds himself or herself has, after such investigation as he may deem fit, granted written authority for the sterilization; and

[Para. (*b*) substituted by s. 1 (*a*) of Act No. 38 of 1980.]

(*c*) the Minister, or a medical officer of the Department of Health authorized thereto by him in writing, has granted written authority for the sterilization.

[Para. (*c*) substituted by s. 1 (*b*) of Act No. 38 of 1980.]

(2) The person who may consent to an operation as contemplated in subsection (1) (*b*), is hereby authorized to grant the consent referred to therein.

(3) The provisions of this section shall not be construed as affecting the position in law of any person capable of consenting or competent to consent to an operation on himself.

5. Place where abortion or sterilization may take place.—(1) An abortion may be procured and a sterilization contemplated in section 4 may be performed only at a State-controlled institution or an institution designated in writing for the purpose by the Minister in terms of subsection (2).

(2) The Minister may designate any institution for the purposes of subsection (1), and subject to such conditions and requirements as he may consider necessary or expedient for achieving the objects of this Act, and may, if in his opinion it is justified, at any time withdraw any such designation.

(3) A decision of the Minister in terms of subsection (2) shall be final.

6. Approval by medical practitioner in charge of institution, and certificate by magistrate.—(1) An abortion shall not be procured and a sterilization contemplated in section 4 shall not be performed without the written authority of—

(*a*) in the case of a State-controlled institution, the medical practitioner in charge of such institution or a medical practitioner designated for the purpose by the first-mentioned medical practitioner; or

(*b*) in the case of an institution designated in terms of section 5 (2), a medical practitioner designated for the purpose by the person managing such institution,

granted on application to such medical practitioner in accordance with subsection (2).

(2) An application for authority in terms of subsection (1) shall be made in the prescribed form by the medical practitioner who is to procure the abortion in question or perform the sterilization in question, and shall be accompanied—

(*a*) in the case of an intended abortion—

(i) in the circumstances contemplated in subsection (4), by the certificate referred to in that subsection;

(ii) by the certificate or certificates referred to in section 3 issued by two medical practitioners;

(*b*) in the case of an intended sterilization, by the certificate or certificates, consent and authority referred to in section 4.

(3) If a medical practitioner has issued a certificate for the purposes of section 3 (1) and he is at any time such a medical practitioner as is referred to in subsection (1) of this section, he shall not be precluded from granting any relevant authority for the purposes of the said subsection.

(4) Where the pregnancy is alleged to be the result of unlawful carnal intercourse, the abortion shall not be procured unless there is produced to the medical practitioner whose written authority is required in terms of subsection (1) a certificate, issued by a magistrate of the district in which the offence in question is alleged to have been committed, to the effect that—

(*a*) he has satisfied himself—

(i) that a complaint relating to the alleged unlawful carnal intercourse in question has been lodged with the Police or, if such a complaint has not been so lodged, that there is a good and acceptable reason why a complaint has not been so lodged;

(ii) after an examination of any relevant documents submitted to him by the Police and after such interrogation of the woman concerned or any other person as he may consider necessary, that, on a balance of probability, unlawful carnal intercourse with the woman concerned had taken place;

(iii) in the case of alleged incest, that the woman concerned is within the prohibited degree related to the person with whom she is alleged to have committed incest; and

(*b*) the woman concerned alleges, in an affidavit submitted to the magistrate or in a statement under oath to the magistrate, that the pregnancy is the result of that unlawful carnal intercourse.

[Sub-s. (4) amended by s. 2 of Act No. 38 of 1980. Para. (*b*) substituted by s. 4 (*a*) of Act No. 48 of 1982.]

(5) .....

[Sub-s. (5) deleted by s. 4 (*b*) of Act No. 48 of 1982.]

(6) If an application complying with the requirements of this section is made to any medical practitioner referred to in subsection (1), such medical practitioner may institute such investigation as he may deem necessary in order to satisfy himself that the application complies with the requirements of section 3 or 4, as the case may be, and if the medical practitioner concerned is so satisfied, he shall grant the authority in question.

[Sub-s. (6) substituted by s. 4 (*c*) of Act No. 48 of 1982.]

7. Reports.—(1) A medical practitioner who under section 6 (1) grants authority for an abortion or a sterilization, shall, in the prescribed manner and within the prescribed period after the abortion or sterilization, by registered post report confidentially to the Director-General the granting of such authority and set forth—

(*a*) the name, age, marital state, race and, in the case of a sterilization, the sex of the patient concerned;

(*b*) the place where and the date on which the abortion was procured or the sterilization was performed, and, in the case of an abortion, the reasons therefor;

(*c*) the names and qualifications of the medical practitioners and the name of the magistrate who issued the certificate or certificates in terms of section 3, 4 or 6, as the case may be;

(*d*) the name of the medical practitioner who procured the abortion or performed the sterilization;

(*e*) where the consent of any person other than the patient was required for the abortion or the sterilization, the name of the person who consented thereto, and the capacity in which he granted his consent.

[Sub-s. (1) amended by s. 5 (*a*) of Act No. 48 of 1982.]

(2) The Director-General may call upon a medical practitioner required to make a report in terms of subsection (1) or a medical practitioner referred to in subsection (1) (*d*) to furnish such additional information as he may require.

[Sub-s. (2) amended by s. 5 (*b*) of Act No. 48 of 1982.]

(3) The person in charge of an institution where an operation connected with an abortion or the removal of the residue of a pregnancy is performed, shall keep or cause to be kept a record of the prescribed particulars in respect of any such operation in that institution, and shall—

(*a*) when called upon to do so, make such record available, for inspection, to the Director-General or a person authorized thereto by him in writing; and

[Para. (*a*) amended by s. 5 (*b*) of Act No. 48 of 1982.]

(*b*) transmit to the Director-General at the time prescribed the prescribed information with reference to any such operation.

[Para. (*b*) amended by s. 5 (*b*) of Act No. 48 of 1982.]

8. Regulations.—The Minister may make regulations—

(*a*) prescribing the form in which an application shall be made or an authority shall be granted in terms of section 6;

(*b*) as to the custody and disposal of certificates and reports in terms of this Act;

(*c*) as to the particulars of the records to be kept in terms of section 7 (3);

(*d*) generally as to any matter in respect of which he deems it necessary or expedient to make regulations to achieve the objects of this Act.

9. Participation in or assistance at abortion which is not prohibited, or a sterilization.—A medical practitioner (other than a medical practitioner referred to in section 6 (1)), a nurse or any person employed in any other capacity at an institution referred to in section 5 (1) shall, notwithstanding any contract or the provisions of any other law, not be obliged to participate in or assist with any abortion contemplated in section 3 or any sterilization contemplated in section 4.

10. Offences and penalties.—(1) Any person—

(*a*) who is not a medical practitioner and procures an abortion;

(*b*) who is a medical practitioner and—

(i) procures an abortion without an appropriate certificate or certificates issued by two medical practitioners in terms of section 3 (1) (*a*), (*b*), (*c*), (*d*) or (*e*); or

[Sub-para. (*i*) substituted by s. 6 (*a*) of Act No. 48 of 1982.]

(ii) procures an abortion or performs a sterilization—

(*aa*) at an institution other than an institution referred to in section 5; or

(*bb*) without appropriate written authority referred to in section 6 (1);

(*c*) who performs a sterilization in contravention of section 4;

(*d*) who issues a false certificate for the purposes of section 3 (1) (*a*), (*b*), (*c*), (*d*) or (*e*) or 4 (1) (*a*);

[Para. (*d*) substituted by s. 6 (*b*) of Act No. 48 of 1982.]

(*e*) who grants any written authority referred to in section 6 (1) without being in possession of an appropriate certificate referred to in section 6 (4),

shall be guilty of an offence and liable on conviction to a fine not exceeding five thousand rand or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment.

(2) Any person—

(*a*) who grants a written authority contemplated in section 6 (1) on an application which does not substantially comply with the requirements of an application as prescribed;

(*b*) who contravenes a provision of section 7 (1) or (3);

(*c*) who fails to furnish the additional information required of him under section 7 (2);

(*d*) who fails to comply with any provision of this Act not mentioned in this section,

shall be guilty of an offence and liable on conviction to a fine not exceeding two hundred and fifty rand or to imprisonment for a period not exceeding three months or to both such fine and such imprisonment.

11. Application of Act in South West Africa.—(1) Subject to the provisions of subsection (2), this Act and any amendment thereof shall also apply in the territory of South West Africa, including the Eastern Caprivi Zipfel.

(2) For the purposes of subsection (1), any reference in this Act to section 15 of the Immorality Act, 1957 (Act No. 23 of 1957), shall be construed as including a reference to section 2 of the Girls' and Mentally Defective Women's Protection Proclamation, 1921 (Proclamation No. 28 of 1921), of the Administrator of the territory of South West Africa.

[S. 11 substituted by s. 1 of Act No. 18 of 1976.]

12. Amendment of section 2 of Act 38 of 1909 (Transvaal), as amended by section 19 of Act 26 of 1963.—Section 2 of the Criminal Law Amendment Act, 1909 (of the Transvaal), is hereby amended by the deletion of subsection (8).

13. Short title.—This Act shall be called the Abortion and Sterilization Act, 1975.

APPENDIX C

PROPOSED FREEDOM OF CHOICE (ABORTION) BILL

FROM THE REPORT OF THE AD HOC SELECT COMMITTEE ON ABORTION AND STERILISATION

(JUNE 1995)

(f) Some of the submissions pointed out that the Act does not distinguish between different stages of pregnancy. They referred to evidence that abortion during the first trimester is far safer than abortion later. They said that in other countries, where abortion is available, 80% of abortions take place in the first trimester, but that the Act does not acknowledge this difference or facilitate abortions in the earlier stage.

(g) ARAG put forward a Bill to replace the current Act. This proposed Bill is also attached as an appendix to this Report. [*See* Appendix D.] The Bill proposes many changes. Among the most important is the proposal that abortion should be available to all women, if they so choose, up to the 14th week of pregnancy, and that it also be available up to the 24th week, but that other factors besides the woman's request be considered at this later stage.

(h) Many of the "pro-choice" submissions in general supported the ARAG Bill. However, most of them proposed certain amendments. Some of the commonly suggested amendments included the following:

(i) That the performance of abortions, particularly during the first trimester, not be restricted to doctors, but that a wider range of health personnel be trained and authorised to carry out the procedures at this early stage so that it can be more widely available, even in outlying clinics.

(ii) That the statistics specified in the Bill be gathered, but that the woman's name not be handed over to the authorities responsible for gathering the statistics.

(iii) That the Bill explicitly provide for the woman to have the option of counselling, before as well as after abortion, and that pre-abortion counselling be mandatory for those below 16 years of age.

(iv) That the Bill be explicit in stipulating that the consent of the woman's partner is not required.

(i) Several of the "pro-choice" submissions felt that the issues of abortion and sterilisation should be clearly separated, and that they should therefore not be dealt with in the same Act.

(j) Many of the "pro-choice" submissions stressed freedom of conscience. They said that all health workers concerned should be free to refuse to participate in the abortion procedure, but that those who refuse, would need to refer the woman to someone who is prepared to participate.

6. *Recommended legislation*

(1) The Committee recommends that the current Act be repealed.

(2) The main thrust of the changes introduced by the envisaged new Act should be as follows:

(a) The Act should provide for abortion, on request of the woman, up to 14 weeks gestational age, and between 14 and 24 weeks under certain broadly specified conditions.

(b) The current cumbersome, time-consuming and discriminatory procedures should be simplified. The requirement that two doctors should be consulted, should be removed. A wider range of health personnel should be trained and authorised to perform abortions, additional health facilities should be provided and existing ones should be improved in order to increase access to women in areas where there are fewer doctors, if any.

(c) Counselling should be available to all women requesting abortion, but it should be non-directive. It should be non-mandatory, except in the case of minors.

(d) The consent of the woman's partner or husband should not be mandatory. In the case of a minor, she should be advised to consult parents or responsible family members or friends, but abortion should not be denied if she does not choose to consult.

(e) Statistics should be collected by a central authority. The name and identity of the woman should not be passed on to the central statistics collection point.

(f) Any doctor or other health worker who has conscientious objections to taking part in the abortion procedure, should be free to recuse himself or herself. They must, however, refer the woman to others who are willing to take part in such procedure.

(g) The issues of abortion and sterilisation should be clearly separated and should therefore not be dealt with in the same Act.

The Committee recommends accordingly.

S A NKOMO
Chairperson.

Committee Rooms
Parliament
29 June 1995.

APPENDIX D

INTERVIEW TRANSCRIPTS

1. Candice
2. Lindiwe
3. Yumna
4. Portia
5. Ferial

Name: Candice
Age: 28
Residence: Cape Flats, with family
Marital Status: Single
Number of Previous Pregnancies: None
Number of Children: None
Years of Schooling: Tertiary
Occupation: Student
Religious Preference: Christianity
Psychiatric History: None, growth-oriented psychotherapy

Interview:

S: I would like now for us to talk about your experience, and really for you to start where it feels most comfortable.
C: Okay, I think just to start off with, there was a lot of ambivalence around having the abortion. You see, I was set on having it, it was something that I wanted to do, needed to do, it seemed right. But the longer that I had the baby inside of me, it became increasingly difficult. I was fourteen weeks when I terminated so it was a long time into the pregnancy. So the ambivalence made it worse for me. It was extremely stressful and I think ...umm... at the end of the day I'm not sure if I really sorted through about having this baby or not but was just being pulled in two directions which most of the time made it very difficult. And I didn't know myself which was the best solution, I kept looking outside and outside and outside and I wasn't getting that clear cut advice at the time ... do it or don't do it and that was difficult.

S: You speak about the ambivalence and the two pulls in different directions. Can you tell me more about that.
C: Yes. The one thing that made it difficult to consider having the baby was that it wasn't a very stable relationship at the time and also that I was involved in another relationship at that time too. Umm... the one in which I conceived was quite an important one for me as was the other one, but I was sexually involved in the one in which I conceived. So in terms of relational stuff, it was difficult. The other difficulty around having the baby was that the relationship in which I conceived was an unstable one and not a very supportive one. The person there was more invested that I terminate at the time. Yes.

S: When you say that 'invested in', does it mean that you experienced some form of coercion from this man.
C: Yes, in fact there was a lot of that. Umm... there was a lot of emotional umm... what ... pressure to do things. This person was quite withdrawn at the time and it was extremely difficult to make contact with him. He alluded to, he never said that he would, of possibly taking his life at the time, which was very difficult for me. Yes, it felt like there was quite a bit of pressure. The other thing is that I was at university and it also meant making decisions around that. It is a set programme and it meant that if I had this baby I would not have been able to complete my studies and I was feeling very insecure about that 'cos it was very important to me, it meant a whole lot of things in terms of my independence, but also it brought up my own insecurity around my academic and professional work, so it was that kind of edge, that kind of uncertainty about myself, whether I could care for a baby. At times I fantasised about having this baby by myself, but financially I was not in a position. Umm... also in terms of family support it would have been very difficult because this relationship was not condoned or supported in any way by my family. In fact, at the time my mother, particularly, asked me to leave home because of this relationship, so it was extremely difficult.

S: It must have been difficult then to expect support from your family. What about other support systems?
C: You know, Shahnaaz, at times like that you don't quite think clearly to start off with. I remember thinking ...umm ... yes, I had some insurance policy and there was a loan of about R2000-3000, R2800 in fact against it. And I took that money, thinking that I was going to need to this money, this money was going to take me through and I went house-hunting at the time. But then I sat down and realised that R2800 would not go a far way. Umm... so at one point I thought that I could do this and there was a fantasy for me to do some of that but soon after that reality struck and I realised that it was not possible. I was going to have to reach out, I was gonna have to ask and it meant a whole undermining of my own independence. Up until then I felt very dependent on people, I felt even dependent to the point that I wanted people to make decisions for me ... and I went house-hunting just before I decided to terminate, and there was this little dilapidated separate entrance and all that I could afford ... damp walls. Suddenly I realised that this is not what I want for a baby but particularly not for me, and it just seems like that the fantasy was extremely fulfilling but that if this was going to be my reality I would ... I would

... I don't know that I would have ended up liking myself, I just felt extremely demoralised I think, umm... I would have been depressed if that was the situation. But that wasn't all, I think there was a need to be independent even when it was really difficult - there were friends, lots of friends and even family I suppose would have been okay if I went to them. But it was difficult at the time. It felt like - you know what - you're an adult, you're not a 16 or 17 year old, I was 28 at the time. Umm... and if I was going to take make this decision I was going to have to take responsibility and at the time I couldn't. You know it wasn't just financially, I think that some of that could have come together 'cos I'm not as proud as I'm suggesting now, but umm... (tearful, long pause) it was a combination of factors.

S: I can see that you feel very sad about what happened.
(Pause). What is also striking for me is that you talk about the baby - was that how you related to it?
C: Yes. (Tearful) You know what - strange things happened to my body. It wasn't clear to me initially that I was pregnant. I remember doing an exam and I felt extremely ill and even before that when I was studying. I didn't understand it, I thought it was about not sleeping well, about anxiety and I took things like Calmettes and that kind of medication. I remember going for this exam and I felt ratty inside and I felt like vomiting and I felt this anxiety through my whole body, and I couldn't think straight and I put it down to pressure because it was an anxiety-provoking situation because of academic pressure. And then increased in its intensity and occurrence and I couldn't just put aside and I went to a gynaecologist and she said that she thought that I had a growth of some kind.

S: Did you suspect that you were pregnant at the time?
C: I wasn't sure, I thought anxiety and when she said 'growth', I thought yes for sure I'm ill. But I was sexually active, I was on the pill. I changed pills at the time, and I'm not a good pill-taker, so it was not impossible. And then I went for a scan to Groote Schuur because she thought something was wrong, and then it was a very, very tiny baby - the exact words. They thought there may be some kind of deformity at the time.

S: What were your feelings when it was confirmed that you were pregnant?
C: There was some relief because when she spoke about a growth she spoke about cancerous cells, so there was relief on that level. But in fantasy ... I wanted to have that baby, yes I would have liked it (smiling). So it was a mixture of things - Oh, my God, what am I going to do about this, devastation, but at the same time there was a baby inside of me. Umm ... (tearful) ... the longer that I held on to it, the more connected I became to it. I could see a lot of physical changes ... (tearful).

S: So you felt a meaningful attachment to this pregnancy. How did that impact on your decision-making?
C: Yes, it was difficult. I remember making quite an impulsive decision the day before I terminated the pregnancy. (Pause) ... At the time I was sharing a house with the person that I was sexually involved with - just for a short time and it was extremely difficult emotionally, partly because of what I brought but also because of how he related. And then, I needed relief I suppose, I made contact with the other person I was telling you about. And it was such a breath of relief and sunshine when I with him, we related so differently to the way it was with this other person, and I suppose I thought if I had this baby I would be throwing this away as well. Because I had some fantasy that he would support me, and he may have, but I thought no, that he wouldn't be able to take responsibility for someone else's child. And it was just so affirming to be with someone who respected you, liked you ...umm ... who wanted to be with you. And I went back to the other person and there was this withdrawn person, he seemed to depressed at the time, and I made a decision. I said to him, "I'm going to go through with the termination". And he changed immediately, he was supportive and caring and made the arrangements in an hour, and it was all happening so fast. When I got there the next day - it was out of Cape Town - I begged him and the person to give me time and not do it 'cos I was extremely upset.

S: What exactly were you feeling at the time?
C: I was feeling panic, absolute panic. I was hysterical. (Tearful).

S: And how did they respond to you?
C: The person who did the termination wasn't unsympathetic, but it was clear that he had a lot of other things to do that day and he needed some certainty from us about what was happening. I remember going to the bathroom at the time and this person that I was with - I said to him: give me time, I'm not sure that this is what I want, that this is what I can do for now, and I remember him also being so upset. Umm... I suppose I convinced myself and was convinced in many ways that this is what needed to happen. (Pause). Yes, I remember lying on the bed and feeling that I was going to die, it was extremely uncomfortable, painful 'cos it was quite advanced and he didn't

use ...umm... general anaesthetic ...umm ... I'm not sure that this is applicable. So I was very aware of what was happening.

S: Candice, yes I would like some to know about the abortion procedure.
C: It was a gynaecologist that worked outside of Cape Town, and was sympathetic to women who wanted to terminate, and he did it for a very cheap price. He was a middle-aged man, and I found him to be ...umm... I think he cared and that's why he did it, he certainly didn't do it for financial reasons. But he didn't engage much, with me anyway. He attempted at the time to provide some kind of counselling, he said: look, maybe you should go off and look at things but you need to tell me about it. But that was clearly not what he was in to, he expected you to be quite worked out about your decision once you got to his office. Umm... I found him to be extremely efficient medically, professionally, in terms of what he was doing. There was no after-effects. He did a D&C. Because I was 14 weeks, he used forceps. There was a lot of pain, a great deal of discomfort. He used some anaesthetic, local, but I could feel everything. I could feel how he pressed on my tummy ...umm... I could feel when he tugged, when he pushed and he pulled, I felt a lot of pressure on my lower back. It was painful, I remember feeling, not only emotionally but also physically, that I was not going to make it. I kept thinking: I'm going to die, I'm going to die - that's how it felt. I didn't die ...umm...

S: I have a sense, from listening to you, just how difficult this was for you. Candice, how has this experience impacted on you?
C: I think I withdrew quite a bit, not a withdrawal that was quiet. (Pause). Inside it was ... it was ... it was a loss, an emptiness. (Tearful). And I couldn't understand because there was supposed to be relief and I did not feel the relief - some, yes, because I could continue with my studies. Umm... I made other decisions in terms of my life. I continued to look for a house ...umm... at some level, I got up and I did things, I continued. But immediately after the termination, I remember I felt very confused. I was alone, two days after that, and I remember screaming and shaking. I then made arrangements to get back into therapy.

S: Were you in therapy when you initially discovered that you were pregnant?
C: No, I was in therapy, but I had terminated a few weeks before I found out, because of financial and other reasons. So there had been no pre-abortion counselling. Yes, so there was that kind of reaction and I knew where it was coming from, but it was extremely stressful. I felt ... I felt like it was all happening inside of me, and it was difficult to articulate what it was, why I was feeling this, this panic inside, this emptiness, this confusion. And I felt so insecure about my own mental health at the time. I would try to prevent being myself. I remember one day two weeks after that ... I entertained strange fantasies ... I felt like I couldn't trust what was happening inside of me. I also noticed, shortly after the abortion, that I would feel extreme anxiety. I had to get medication for a short while. Mostly, I managed to work it out, it straightened itself out because I didn't continue with the medication for a long time. Also I used my therapy. I used to have weird dreams, some of them not so weird but related to baby things. I used to dream of a baby's hand on my cheek - it was a recurring one. I enjoyed the feeling that came from the dream, it was nice. But, I always woke up and sobbed because it was not there, it was gone.

S: So there was a deep sense of loss that you were feeling at the time?
C: Yes, it was. Loss of a lot of things, loss of a baby, loss of a fantasy of something ... of a perceived connection, loss of trust in the relationship. I felt extremely manipulated, as I explained some it before. What happened affected this relationship in a big way. I must say that at the time I felt that all the connection and bonding and the arrangement to stay at his house was around the pregnancy, it was not around the relationship. So I was acutely aware of that, that it was not something that happened in a natural organic way, it was something that was imposed and reacted to. And that was very uncomfortable for me, and I knew that once the termination happened things would change. So I was under no illusion that it was loss. In a strange way I enjoyed some of that closeness and bonding that I derived from the pregnancy, so I'm aware of that. Umm... for me it felt that once the termination happened, other things came to an end as well. You know, what freaked me out was that I was feeling all this confusion, things I couldn't talk about, that I couldn't make sense of, and it felt like he got on with his life. Maybe, that was not how it was, but his mood lifted, he was doing things, he was going out, he was carrying on. I think I carried on too, I set up home with someone else, I continued with my studies ... umm... and I engaged more with the other person I told you about. But I carried the impact of it in a big way. Right now as we're talking it feels like I'm going to carry this around with me for the rest of my life, you know ... (Tearful). And I can't help but feel angry about this, and I wish, and now I only have fantasies about it, that he could just take the risk of creating the space with me to talk about it, and he's feelings wouldn't have to coincide with mine. So

that was very difficult. And I couldn't go to my family. I have one close friend that I could speak to very openly, and that helped. But it was like having to mourn in a closet.

S: Because abortion is something that we don't talk about?
C: Yes, and because of the stigma of having an abortion, also my own guilt, some of it linked to my religious background - it says abortion is ... well, it is pro-life.

S: Yes, I would like to know about your own attitudes to abortion.
C: Intellectually, I think that I'm pro-choice. Umm... more than the religious guilt and any other kind of guilt, I believe women should make those decisions for themselves. I think, in retrospect, I made that decision, I felt coerced and felt a lot of pressure to do what I did. I know I'm pro-choice, but at the same time, given my experience, I don't know that it's just about being pro-choice or pro-life 'cos I think that an abortion can bring with it a lot of relief, but it can bring a lot of pain as well, and if you don't work through it properly before we go into that kind of situation, I think you just sit with so much at the end.

S: Which has been your experience. How have you coped with it?
C: I think talking about it, talking to people who understand, and there have been very few people that I have spoken to about it. Umm... working through on my own, I think about it often, I read about it, so psychologically, I have some idea what happens - that helps. But, like I said before, it's not gone, even though I understand it intellectually, the pain is not gone because I think what happens, Shahnaaz, is that an abortion is not just about the termination of a foetus - it's often a termination of parts of yourself in a relationship, and I think it's not just the baby ... the baby is important, but it's other fantasies as well. And how do you go back and how do you mend something that is broken forever - I don't think you can, I haven't been able to, and its coming to grips with the bigger loss, the loss that is bigger than the baby. That has been my experience. You know, I can't help but think that if it was someone I wasn't particularly interested in, I would be saying things similarly but with less intensity.

S: So the termination of this pregnancy occurred in a very particular context for you, and that context was a significant relationship. Candice, before you terminated, did you have any idea of what it was going to be like, and what were your expectancies about how you were going to cope with the experience?
C: I knew that this was how it was going to be. My expectancies - I thought I was going to get on with my life, and that I'd be angry for a while, I'd feel loss for a while, but I would get over it. Umm ... so some of that worked out well.

S: In general, how do you cope with stress?
C: I think I express a lot of it emotionally, so that helps. When I'm feeling emotionally and physically stressed, like when I'm sad, I allow it happen, I cry, I create space where I can express whatever I feel. I know when there is a lid on it, it feels like something is going to explode, and it has exploded for me at points. But I understand it, and I try to prevent that for myself. So, I try to express it as much as I can - it's not a conscious thing, it's part of who I am.

S: So would you say that this style has helped you in dealing with what has been a very difficult experience?
C: It helped in a big way. Even though the relationship has not worked, there is a site that I can take things to, even if it's anger or destruction, I took it the relationship at times, and that it must have helped. It would be so nice if there was a group I could go to, where women had similar experiences, and integrate it in a different way. But often, I spoke to a friend and she understood a lot about it, and that helped.

S: What, then, would you say would help women in similar situations? You've made references to certain things - can you say more about them?
C: I think pre-abortion counselling, I would definitely support it. As far as possible, I would like to see the couple committing themselves to that process. I think it's so important, it helps you to separate things from the relationship, if that's at all possible. To see what it means to have a baby, what it means to be a single parent, to have the baby within the relationship, and to be under no illusions about anything, so talking through and being extremely honest with each other. I would have appreciated that a lot more rather than the experience of manipulation and blackmail. I couldn't think straight, and I wasn't given that kind of focus from the outside as well, not with the person I was involved with. So abortion counselling is so vital. An objective presence. Someone who understands what it's like for the women, both emotionally and physically. For me, there were a lot of changes during pregnancy. Small things, like a tummy that is growing, and that's a big deal for you, your breasts feel swollen and tender, and it's a big deal, and that's not nothing. So there must be space for the women

to say what it's like even if it seems unimportant at the time, 'cos if you don't listen to it, you don't acknowledge it. Umm... years later you may still long for that or you may still relate to it. So I think it's as difficult for men as it is for women, but for women particularly, because their experiences are unique as opposed to the man's experiences. And to understand why it happened - because of contraceptive failure or because of an unconscious connection or fantasy. If you don't look at it, there may be effects to look at later.

S: What about after the abortion, what are your thoughts about post-abortion support?
C: I think what would have been helpful for me - to keep the issue current, not to let it go away because now your studies are on track, you're in another relationship, but to talk about it. Maybe, a support group with other women. Shahnaaz, maybe not immediately, but later on to have these options where women can contact people who can provide the service. I think that there is a lot to deal with, some women may feel relief, or depression, anxiety. When you're still agonizing about it a few months later, it would be nice to talk to other women, to listen to other experiences. Some of that would have helped me, not to mourn in a closet. Also individual counselling. My own experience, it helps, but a male therapist, he did his best to understand, but I don't think he really understood. I couldn't help but think that if I had a woman therapist, someone who experienced something similar, it would have been a different experience. I didn't feel like he really understood.

S: And now ...
C: It was extremely tough, the toughest journey that I undertook in my life. But some of it feels like it has healed already. This is not the way you want to grow emotionally, but in my case, I have grown, I've learnt more about myself. So that's how it feels now. If I had some pre-abortion counselling, and had some opportunity to talk it through honestly and rationally with the person I was involved with, I would not have felt as much confusion, as much ambivalence, during and after. Umm... I think I would have been able to come up with a clearer decision - to have the baby, or not to have the baby. I feel I didn't do that for myself, there was no space to do it. And that blurred a lot for me. And I feel angry even with the person who performed it. I suppose it's about not being able to be angry with myself ... (Tearful).

S: But real anger, because you were expressing something at the time, and your experience was that you were not listened to.
C: Yes, and I suppose that's what I feel towards the person I was involved with. At times, though, it feels like it's a bit better. But it's there, it takes a little thing to tip it, to be reminded that I'm angry, I'm resentful. It's about the lack of openness, although now as I talk I don't have a need to talk to him, because it has passed, I've almost mourned it, it's gone.
S: You use the word 'mourn' in relation to your experience of loss. Can you tell me about your mourning process?
C: I think a lot my expression is quite private. Umm ... some strange things, I've held on to things that remind me of the experience, little things. Umm ... I have the scan photograph, for example. Some of it, I have separated from, I have buried some of it, but I still have a lot of it. And I know ... (Tearful) ... it's in a special bag in my cupboard, and when I'm ready, I will bury it completely. I will do it in phases. I have taken on some private rituals around it, to help me mourn. Yes, that is all.

S: You have shared a great deal with me. You have shared about an experience that clearly has been emotionally hard. I wish to thank you for that. I'd also like to know how you feel about having shared your experience with me ...
C: I find this kind of expression healthy for myself. You know, I'm not able to talk about it without becoming quite emotional, but that does not hassle me, it must happen. I think that by doing some of this, it validates my experience. It makes it feel less of a closet experience. I'm also invested in research in areas concerning women, so I feel like this is something I want to do, and I need to do. Emotionally, it gave some space for ventilation. It was fine to talk about it, I didn't feel any pressure from you, I had the space to talk about it in a way that felt fine for me. I just also want to say: I'm for the legalisation of abortion, but I have difficulty with it not being paired with counselling. Allow women to feel and work through before they make the decision. Even though this experience does not jeopardise your mental health, it causes strain, and I certainly know what that feels like. So there must be some model for providing support to women. I don't know if this study ...?

S: Yes, I am hoping that the findings from this study will, to some extent, inform the area of abortion counselling. As you may already know, there is the possibility that new legislation will be passed soon. One of the recommendations is that non-directive counselling be offered to all women considering termination of pregnancy.

C: And post-abortion counselling is also important.

S: Candice, once again, thank you so much for sharing your experience with me. I really appreciate that you made this time to talk to me. Like I said at our initial contact, I will contact you once I have my results together, to sound it out with you, to hear from you if the results are an accurate reflection of your experience as you told it to me. Also, if talking to me has evoked strong feelings for you, and you wish to talk about it, I would like to encourage you to contact me so that we can consider counselling options.
C: Yes. And ... thank you.

Name: Lindiwe
Age: 20
Residence: University Residence, Bellville
Marital Status: Single
Number of Previous Pregnancies: None
Number of Children: None
Years of Schooling: Tertiary
Occupation: Student
Religious Preference: Christianity
Psychiatric History: None

Interview:

S: Lindiwe, as I said earlier, I would like to know about your abortion experience. Is there any particular place where you would like to start?
L: No, you can just ask.
S: All right then, why don't we start with the circumstances around your pregnancy.
L: You mean ...?
S: For example, how did you feel when you discovered that you were pregnant, were you on contraception at the time, what did the pregnancy mean to you ...
L: Well, I didn't suspect it at all. I didn't want to have a baby, I mean I didn't plan it, the baby. It just happened, so it was like that.

S: Were you on contraception at the time?
L: No, not really. Umm, no. Sometimes we used condoms, other times nothing. I don't know, umm ... maybe I wanted to, er ... have a child. But I'm not sure about that, I suppose I don't know for sure. With me and my boyfriend it was like that. If he didn't have any condoms, then I didn't feel free to tell him that we shouldn't have sexual intercourse, so then we didn't use anything.

S: Why was that, that you didn't feel free to initiate it.
L: Umm ... well ... umm, it's not comfortable for me say this, but before the abortion, mostly I allowed my boyfriend to take the lead, to make all the decisions, so it was like that. Now, I, er ... I can see that wasn't the right way, so it's different now with me and this other boyfriend that I have now, er, my present boyfriend that is. But also, er, I suppose me, something about me. I suppose I thought that things like that happen to other people. I was always the one who did things the right way, the proper way. I did not break rules, umm, norms. So I just ignored the whole issue because it was never going to be my problem. Huh! Until it happened to me.

S: So how did you respond when you found out that you were pregnant?
L: Er, first I went to the doctor, to the clinic. You see my boyfriend, he er, he had another affair with someone else and during the time, I mean after that time, we started back together again, and then I started to realize that I had some sort of infection. So I went to go and see a doctor and then from there she asked me whether I had my periods that month. I told her no that I didn't and she said that we must do a pregnancy test to find out if I was pregnant. And the fact was, er ... I was pregnant. When she told me I was pregnant, ja, I was shocked. I hadn't suspected that I was pregnant so it came as a huge shock.

S: Did you have any other feelings about the pregnancy, Lindiwe?
L: Yes, I did. I also had other feelings. I didn't want it in my life, I never intended to have a baby, like I told you just now, but also ... I don't know really, I had mixed feelings because I remember it was like, er ..., er, it felt good that I had a baby inside of me and I didn't want just to give it up, you know.

S: So you had mixed feelings about it?
L: Umm, I don't know really. Ja, I think I had mixed feelings because I remember that same day that I found out that I was pregnant, I went to go and sleep and ja, I felt like that, like I just described. Er ... but also not just that. I was feeling like it was my fault that this happened, er, that I fell pregnant ... I should have been more careful. So anyway, I decided to have an abortion.

S: What were your reasons for having an abortion?

L: A few things, I guess. I simply wasn't ready to be a single parent. The relationship was not in a good way, he was on his way out, and I was going to be left alone with the baby. As a single parent you need, umm, financial resources, and er ... er, good support, and I didn't have some of that ... definitely not the money. As you know, I'm a student here. As a student, my mother, who is also a single parent, is supporting me, and it's a struggle for both of us. I would never manage with a child, and nowadays it is so expensive to bring up a child.

S: You said there were a few reasons ...?
L: Yes. Also my studies. I really wanted to finish my studies. And, well, I just decided that I couldn't ... also my mom. I couldn't tell my mom that I was pregnant, she would have been very disappointed. She would be disappointed about it all because she wants me to do well in my studies and to finish my degree. She is working very hard for both of us and I knew that er ... er that I just couldn't bring another person into the world for her to take care of. That is why I felt that I just couldn't have a baby. I just couldn't ... I mean ... but like I said, er ... it was also er ... confusing, mixed. It's just that knowing that there's someone growing inside of you. I don't know how umm ... can I explain it. It was just ... knowing that there is a baby growing inside of you, I pictured what it would look like, what it would feel like to be a mother, something like that, umm ... I thought of my child everyday ... I even thought of names for my child, but I also wanted to have an abortion. So it was like that.

S: It sounds like you were ambivalent about your decision. You also mentioned earlier that perhaps at some level you wanted to have a baby.
L: Yes. I would have liked to have had a child. [Sigh]. And also my boyfriend.

S: What about you boyfriend?
L: He was also a reason, I think another reason for the abortion because er ... we were going out for a short time and it wasn't a great relationship, we quarrelled a lot. I remember one day we were talking about what to do about this situation, and er ..., umm, I said maybe we must wait a bit before we decide for sure. I don't know, but something like that, you know, let's first talk and see. All that he could see, say er ... was that, he said that he can't wait and that I must know that otherwise he's out and that's one of the things that forced me to have an abortion.

S: Lindiwe, did you feel coerced by him to have the abortion?
L: Ja, I did. I felt like that because er, because when I said maybe we must wait and see, when I told him maybe I should have the baby, er ... he said, "No you can't do that", that's what he said, and also er ... that I must just have the abortion ... there were times that I felt that he forced me and that was very stressful for me. He didn't want the child, he just didn't want the child, that was clear for me to see. He used to come to my room and I used to say that if we weren't going to be successful in getting the abortion, then he might as well accept the child and he just said no, that wasn't possible. He said that I really couldn't, er ... he said that if we can't have an abortion then we just have to think of other means like maybe adoption and I said that I can't settle for that, adoption. He just showed me he didn't, er ... [tearful] he wanted me to ... have the abortion.

S: That must have been hard on you?
L: Yes. So anyway, er ... I then had the abortion. I found someone to do it for me, and, umm ... that's how it happened in the end.

S: Lindiwe, I would like to know how you went about finding someone to perform the abortion, and what that whole experience was like for you.
L: Before my abortion, I had heard that some doctors do it for you, and I asked this person, this lady that I knew, I told her everything and she told me about this doctor that might help me, that's what she said and er ... she said that she wanted to be anonymous in all of this. This doctor was somewhere in town. And I went there and I didn't really know the way to the doctor and this other women just said to me, "Are you pregnant?". I told them, "Yes I am pregnant", and the one woman showed me where to go. And right there, er ... I told them that I was looking for this doctor who performs abortions, and they told me that yes I must go to him and maybe those pills can help me. So I went to the doctor and ja, er, he agreed to do it. He told me what he would charge for the abortion and I said fine. It cost me something like R1000, but I was desperate so I borrowed some money and I used some of my bursary money. I just thought that I must do it because it ... er, the time was going and I had to do it quickly, umm, before it was too late.

S: How many weeks were you at that point?
L: I was almost four months.

S: Lindiwe, what procedure did he use?
L: So I had make another appointment with him. He gave me some pills to take and er ... I think, er, what they call it, a D&C, that's what he did. It, er ... I was drowsy so I'm not sure what he did at first. And then, I think he cut the placenta and I just felt the blood and everything coming out ... er, I don't know how to explain, it was like birth pains and it lasted for about two to three hours. I don't what it's like giving birth but it was like that. And then it all came out, er ... but I didn't want to see the child.

S: That would have been difficult for you ...?
L: Yes, very, so I didn't see. And then there was the pain. It was so painful, er ... and he said that there was still more to come, umm, ... ja ... and I felt like telling him to just stop.
S: It sounds like it was physically traumatic.
L: Mmm, yes. Well, he was trying his best with me I think. And I wasn't relaxed at all, er, and he just said to me, he said that I must try to relax because this is nothing. There's still more to come and when he was saying, like I said, I felt like telling him that maybe he should just stop and maybe I should just go on with my pregnancy.

S: What was he like, Lindiwe? How did he treat you?
L: Well, he was fine with me, he was fine. And that helped, I guess.
S: How did it help?
P: To help me relax, er, because that was important, you know, to relax for the sake of the procedure. Ja, that's what I would say.

S: And after the abortion? I'm interested to know how you felt emotionally.
L: Well, after the abortion I just felt quite relieved because it was now over.

S: Did you have any other feelings, umm, do you have any feelings now about the abortion?
L: Yes, I think so because I also judged myself quite a lot, like why did I do that ... I felt bad about it, er, I felt guilty, er ..., umm ... also you know, I couldn't go to church for a while because of what I was feeling. Because of the guilt, I suppose. So, religion also affected ... that's how I felt. I felt ... I just felt that guilt, umm ... that is why I just couldn't go to church anymore, even when my mother asked me to go.
S: And now, do you go?
P: Yes, now it's ok, I go to church.

S: All right, so you felt both relieved and guilty. What ...? L: No, I also felt like low and down after the abortion, I remember. I just stayed in my room most of the time, umm, because I felt low and down and depressed because it was like I was close to this child, umm ... sometimes I locked myself in my room.

S: Did it feel like you lost a baby?
L: Yes, it did feel like loss. You know, it was like that, as you say, er ... I felt like there was a loss and I felt all this hurt inside me. I felt like there was a space inside of me that needed to be filled. That's why after having the abortion, I was like traumatised, you know, er ... it was like, er ... I was really hurt.

S: Yes, it sounds like you were feeling very sad after the abortion. And now, Lindiwe? What, er, how do you feel now?
L: Now, er, I can say that when I look back I just feel that it was for the best that I had the abortion because it would have been very difficult for me to raise a child. But sometimes I feel that I just want a child so much, umm ... like one time, I saw a pregnant woman and I just felt sad because it reminded me of the abortion and the baby and everything.

S: Lindiwe, how you have coped with the abortion, these difficult feelings that you describe?
L: Yes, it was very difficult for me and I was, er ... another thing, this guy, er, we broke up and he's staying on campus, and I used to see him every day, and every time I used to see him, you know, I just couldn't help but think back. What was so difficult was that it was like nothing happened for him. He got involved with someone else and I would see them together and I had to go through everything on my own. But now it's different because I have someone else in my life. I, er, like get on with my life. I , er ... the guy, umm, now he is out of my mind. I don't think of him anymore, even when I think of him, I think of him as someone who does not deserve me.

S: Would you say that ...?

L: Sorry, but now, er, I can say that I feel normal. Whatever happened is in the past, I just tell myself, umm ... and that I just have to move on.

S: Has that helped, er, does that help?
L: Yes, it does.
S: Lindiwe, did you talk to anyone about how you were feeling?
L: Well, it was just hard because I didn't have any support systems. Also, you can't, er ... talk about this thing to people because then they say, I mean, abortion is seen as a bad thing. So, I didn't want people to know about it, you see, because of the stigma and everything. Anyway, ja. Yes, er ... it was very difficult for me so I went to see a counsellor to talk about it.
S: How was that for you?
L: It was good. She was the only person I could talk to, I could tell her everything that I was experiencing. I tried too hard to forget everything. I suppressed all the hurt, I didn't want to think about it, it was, er ... like that, umm ... I threw myself into my studies. When I saw the counsellor, I realised that I hadn't been dealing with my feelings properly. I'd just been trying to forget about all the things, about everything, you know, I didn't want to think about it. So, counselling helped.

S: Mmm. Lindiwe, what then would you say would help women in similar situations.
L: Well, I wouldn't entirely advise someone to have an abortion, especially is she feels any doubt in her mind or something like that, but it would depend on her. I mean, I'm sure everyone has different experiences and the reasons are somewhat different, umm ... so it would just depend on her.

S: Ok. And if she does go ahead with the abortion, what do you think would help her to cope with it?
L: I really don't know. When I was pregnant, all I ever did was study. I studied a lot.
S: Do you think counselling can help?
P: Ja, I think so. For the support, to talk to someone about it, umm, it helps when someone else understands what you're going through, what you're feeling. I think counselling can help because after the abortion, when I went to counselling, she actually helped me to see. The way we related, er, I could just see the importance of the child in my life, and that is probably why I had mixed feelings. When I think of it now, you can say that I, I suppose, er, maybe I wanted a child, a girl. I don't know, I just felt that I could have related to my child, just watching the child grow. And that's why I felt sad after the abortion, you know, like I lost something. After that I did some things to help me with the whole thing. I gave my child a name. It was a way of accepting what happened, umm, and my feelings and dealing with it. Ja, that's it.

S: Ok. Lindiwe, I'd also like to know about your personal attitudes towards abortion.
L: Well, I am not really against abortion. I feel that if someone else could come to me and tell me about wanting an abortion, I would really understand what she is going through because I can see it for myself and I think I will be ready to support other people if they need it.

S: Lindiwe, are there any other aspects of your experience that you think would be meaningful to share with me?
L: No, I think I said it all.
S: All right, in that case we can end the interview. Before we do though, I'd like to thank you for sharing your experience with me. I really appreciate that you made this time to talk to me. As I said when we first spoke, I will contact you once I have the results together, to hear from you if the results are an accurate reflection of your experience as you told it to me. Also, if talking to me has brought up feelings for you, and you wish to talk about it, I would like to encourage you to contact me so that we can consider counselling options.
C: Ok. Thank you.

Name: Yumna
Age: 31
Residence: Retreat, with family
Marital Status: Single
Number of Previous Pregnancies: None
Number of Children: None
Years of Schooling: Matric
Occupation: Clerk
Religious Preference: Islam
Psychiatric History: None

Interview:

S: Yumna, thank-you for agreeing to talk with me about your experience. I would like to know about all aspects of your abortion experience. I'm wondering where you would like to start first.
Y: Well, at the beginning and how I fell pregnant and maybe something about my relationship.

S: All right then, let's talk about the circumstances around your pregnancy - what happened?
Y: Okay, I was in a relationship with a married man for about two years and I was on contraception before but fell pregnant. When I found out, it was a month or so later and I was quite shocked and horrified because of my circumstances and the fact that I was not stable in the relationship - I mean I was in a relationship, but not a stable relationship where I could have a family, umm, whatever, like normal, umm, so it was not actually an ideal situation, and that was one of the major reasons why I considered an abortion because I would not have been able to manage and I wasn't prepared for this emotionally. As far as financially, I wasn't stable enough and also I didn't have any support really from the man I was having a relationship with because he was married and obviously had commitments. But obviously when I got into the relationship I was, er ..., I knew that he was married so it was really my choice and I suppose at the end of the day when I decided to have an abortion, it was also my choice because it was my life and I had to decide.

S: So, from what you're saying, you obviously had not intended for this pregnancy to happen; you were aware of your circumstances and you took precautions but ...
Y: Yes, I took the pill.
S: And it didn't work?
Y: And it didn't work, but I mean I'd been on the pill for a while so obviously something went amiss, and I took it regularly.

S: You also say, Yumna, that the abortion was your choice. Can you tell me more about the decision-making and how that happened for you?
Y: I would say I made the decision by myself because ... OK when I confronted the man I was having a relationship with he wasn't very supportive, almost blamed me for what had happened because I hadn't taken precautions although I had. But I didn't have any guilt feelings about it because I knew I was quite responsible and he was quite angry because at the beginning of the relationship, when we started having a relationship, it was quite clear that he wasn't going to commit himself in any kind of way as far as marriage is concerned and he had a family; a wife and kids, and he was not prepared to leave them. So, he wasn't very supportive as far as that is concerned and in the end I knew it had to be my decision, it's my body, my life, my decision and it wasn't like I had a relationship with a man who I was going to get married to or anything of that sort. Maybe that would have made a difference. So, he had absolutely nothing to do with my decision, umm, he influenced it of course. Had the circumstances been different, if he had been supportive or, you know, promised a more stable relationship I would have considered.

S: So he didn't directly influence your decision, if I'm hearing you correctly, but given the nature of the relationship, it contributed to your reasons for having an abortion.
Y: Yes, that's how the influence came through and also the way he reacted.
S: How did he react?
Y: He was angry as I said, angry with me and also he made it quite clear that he was not able to take the responsibility in anyway, and that I would be responsible totally because he wasn't prepared for any kind of commitment.
S: So that was an important reason in your decision-making?

Y: That was an important reason in my decision, yes.

S: You also mentioned earlier that you were not emotionally and financially prepared; can you say a little more about that?
Y: Well, financially I was, I am working as a clerk, so I was not earning much, but also, umm, I'm doing well in my work and having a baby would have jeopardised that. Emotionally, it was a shock to my system. It was something that I was not expecting and I think, although I wouldn't say I wasn't emotionally strong and stable but I was'nt emotionally ready for such a commitment and responsibility or anything else. I mean having a child and bringing it up, I mean rearing it is quite a responsibility and you have to be ready for that, you have to be prepared for that and I wasn't, you know.

S: So when did you make your decision?
Y: When I found out, I was about 4 weeks and it took me about another ... umm, ... I knew I had to make a decision soon so it took about another 2 to 3 weeks to decide and find out where and how I could. And also, at that point, I wasn't prepared to tell anybody else, my family, or friends or anybody.

S: Why was that?
Y: Because I knew it would attach some kind of a stigma to my life and at that point in time I was supposedly single, and had no other kind of support systems and I didn't want to go through life having this stigma attached knowing that it was going to affect my life in a major way. And at that point in my life as well, I wasn't extremely comfortable and happy and all of that and I wanted more for myself and this would have definitely been something that would have, I would say what, er, come in the way a bit. Also, my family. I mean, Islamically or according to religion, abortion is prohibited. Besides abortion, adultery is prohibited, so I mean that would have been another issue and falling pregnant when you're not married and single, ... so it was a whole, er, I suppose besides the religious thing, how my family would have reacted because of the religion part of it and because they are quite orthodox and all of that so it wouldn't have been very pleasant, and they definitely wouldn't have accepted it. So, that's how it would have been and I would have obviously lived with them all the time, and I mean I was'nt living on my own or could move out or whatever and that would have obviously influenced my life; how they reacted to me I mean. And however they felt or whatever they did, and as far as my friends were concerned, Ok I'd say just one close friend that I told and she understood, but I mean not the rest of the people. I mean, mostly I didn't have many friends, close friends and also people that I worked with, I wouldn't want for them to know because once again because of the ...

S: social stigma?
Y: Because of the social stigma attached to it, yes.
S: So how, then, did you go about getting information about the abortion; how to find someone, where to find someone ...?
Y: Ok, I called, I went to a doctor, not a family doctor but somebody else. But he wasn't prepared to tell me anything and he wasn't prepared to refer me to anybody because it's illegal and there's procedures that you have to go through and all of that and he wasn't prepared to take responsibility of getting caught. But eventually I did find someone, a doctor who referred me to another woman who he knew would do it, and I explained my circumstances and all of that. He was fairly understanding and supportive, and he referred me to her. So I contacted this person and she took all my details and history and all of that and said she'd get back to me and then she did and said she would do it, obviously for a certain price. It cost me a lot of money, money that I didn't have, but when you're in dire straits, you get the money from somewhere.

S: How much did she charge you?
Y: R1500. This was her business, I gave her money and she did the job. I don't think that she saw her role to be anything else. So I didn't expect anything from her, and umm ... you know, she didn't treat me badly.

S: Can you tell me more about the actual procedure, and how it was for you?
Y: Ok. She performed it at her house. I'm not sure if, ... er, it was a tube kind of thing that she used. She used it to pump some kind of liquid into me. I know it was painful, it was this sharp pain inside. Well, it didn't take long. Er, what happened is that I didn't tell anybody about it, that I was going , my friend knew that I possibly was thinking about it and I drove there to the woman by myself and had the procedure done. After the procedure was done she explained everything that was going to happen, that I would start bleeding, and it would be almost like a heavy period. She said that I must go to the hospital if I possibly got an infection or maybe take anti-biotics

or something. Then I left by myself and went home. By the next day, I was bleeding and I knew that this was it.

S: Did you go the hospital?
Y: No, I didn't. I bled for a few days like she said I would. There were no problems, I mean no infection or anything like that, so I didn't have to go to hospital. In any case, I didn't want them, the people at the hospital to know about the abortion, so I was pleased that I didn't have to go.

S: Yumna, you've explained the procedure to me. But I would also like to know how all this was for you, how did you respond to it?
Y: Although I made the decision and I knew that this is what I wanted, it wasn't easy emotionally to accept the fact that this is a life and it was like murdering a child and getting rid of something that could be alive and I think that for me was the most painful part to accept. And I made this decision and I had to accept it but it wasn't exactly easy so I had feelings of guilt after that. So, I felt angry and guilty; I felt guilty first and then angry. Angry with the person I was having a relationship with. Had the circumstances been different at the age that I was at I wouldn't have minded having a child. But also because of the circumstances, I didn't want to bring up a child just for the sake of having it and bringing it up and not really having to put all of myself in it knowing that this wasn't a planned baby. Yes I was angry, angry at myself for having got into a relationship like that in the first place and guilt because of the fact that, I won't say murdered a child, but I suppose some people would that I had to get rid of a human life. It's like, I don't feel like I've done a terrible thing. But other people will probably say that about me and that's why I feel ashamed to say anything about it.

S: Would you say that the guilt that you experienced was linked to your religious belief?
Y: Absolutely, absolutely, I would say that.
S: Yumna, did you experience any other feelings after the abortion?
Y: I was relieved, relieved because now I could get on with my life and maybe this taught me a lesson and would give me direction. And that I am trying to get over this relationship that I was in which wasn't exactly healthy and get into something that is more stable and something that would give me more kind of direction that I can just get on with my life in a normal kind of way, and I think that is positive, a positive thing that came out of it. Also I felt relieved because I could just get on with my life and not be burdened with the responsibility of having this child because I wasn't ready for it. And also as far as support. I didn't have support from my family because they didn't know, friends which I didn't have much of except for the one friend I had who was extremely supportive, but most of my support had to come from myself.

S: Ja, I'm interested to know how you coped with your abortion experience? You say that you predominantly had to rely on yourself. What about yourself did ...?
Y: Ok, I, umm, all through my adult life, ever since I was young ... , I had to start working when I was young and take responsibility from a young age so I am a strong person and able to cope with lots of difficulties that I had. I think that I deal quite well with things, umm ... when things go wrong or if I'm feeling stressed or something, I always do something about it. And I think my strong personality, that was what helped me.

S: Can you be a bit more specific when you say that your strong personality helped? I get the feeling that you didn't talk about it to much except, perhaps, to this friend that you're close to. For some people, talking helps a whole lot in terms of how they cope with it. You didn't talk about it that much, so you must have done something else to cope. Can you reflect on that?
Y: Talking to the friend about it helped but also by thinking, rationalizing about it in my mind, that I did it for myself and the right reason and that I wasn't forced into it. I did it, it was a conscious decision which was important and because I knew it would have adversely affected my life had I not done it. I felt like this was the right thing for me. I made the decision, I took responsibility, umm ... I took charge of my situation. And so, I felt good about myself ... and if that's how I was feeling ... well, I was going to cope with it. It's what made me feel more confident about myself. Initially, it was difficult, but knowing that and believing in that and knowing that I had made the right decision didn't make it all that difficult.

S: Yes, that's gives a good idea about how you coped with the abortion. Yumna, are there other areas of your life on which this experience has had an impact?
Y: No, not really.

S: Yumna, I take it, from what you say, that you didn't have any counselling either before or after the abortion. Am I correct?
Y: Yes, I didn't.
S: What in you opinion would help women in similar situations and why?
Y: I think that situations like this, when women decide to have abortions, more often than not they don't really have family support and support systems that they normally have in other situations. So they obviously need counselling before and after just in terms of giving them support and making them feel more right about it, I mean, er, so that they know if they've made the right decision. And to help them cope, and I think that's important because especially after ... I think that the people who are maybe doing the abortions should refer those women to counsellors before and after. That wasn't an option for me, the woman didn't suggest or refer me. I never considered it, before or after. I won't say I never thought about it but it wasn't really an option and I managed without it. I feel mostly ok about the abortion. It didn't scar me in any way, so that's that. It is definitely very important and can play a vital part in the recovery of the person emotionally.

S: Yumna, just a final question, what are your attitudes towards abortion?
Y: I think that women should be given a choice depending on her circumstances but also it's her body and she should be given the choice and nobody should make the decision for her. And I think that should be included in the present legislation or whatever because in that way it would allow the people who are having back street abortions and having complications and all of that, you know, would be given abortions in a hospital and in a proper way and wouldn't have to go through that traumatic, back street situation. I think women should be given the choice.

S: I think that you have highlighted some very important issues around abortion and certainly the impact of back street abortion on women. Let's just hope that the new legislation is passed soon. It will make abortion more accessible to women, when they find themselves in the kind of position you found yourself in. Anyway, Yumna, I want to thank you for participating in this study; it has been extremely useful talking to you. I really appreciate it. Like I explained, once I have put together the findings of my study I will come back to you so that you can tell me if it fits with what you've shared with me today. I would like to ask, just before we close, what it was like for you to talk to me and I'm also curious about your reasons for participating in this study.
Y: I think to be able to help your thesis, whatever, would make a difference in some way. I hope that it does, who knows maybe it will make a difference in the present legislation or the one that's to come. But also so that I can talk about it, I'm not keeping quiet about it, umm, just talking about it and getting it off my chest and telling someone else other than the only person who knows, that's my friend. And because I suppose I'm more comfortable about it and I've coped with it and I'd like it to make difference to other women and hope that it does.

S: I think those are really good reasons. Well, Yumna, thank you once again for your time.
Y: Sure.

Name: Portia
Age: 25
Residence: Strandfontein, with family
Marital Status: Single
Number of Previous Pregnancies: None
Number of Children: None
Years of Schooling: Std. 8
Occupation: Factory Worker
Religious Preference: Christianity
Psychiatric History: None

Interview:

S: Portia, thanks for agreeing to talk to me. I have already explained to you what we are going to be talking about today. Where would you like to start?
P: I fell pregnant and when I found out, I decided at that moment that I didn't want the baby. So, I decided to have an abortion.

S: Were you on contraception at the time?
P: Yes. We used condoms, I don't know what happened but it didn't work. We always used condoms, so we were careful in that way.

S: So you must have been shocked when you found out that you were pregnant.
P: Yes, I was. I was traumatised about the pregnancy when I found out, I had not planned to have a baby, so I did not want it. I was clear about it from the beginning. Shooh! It was such a shock. I couldn't believe it, it was the end of the world, I mean I took precautions so it couldn't happen and then I fell pregnant, so, umm, I felt like "How's my life going to work out?" At first I didn't suspect that I was pregnant because we were safe and also because my periods are very irregular. I always have that problem with my periods and er ... once I told my doctor about it and he said that I musn't worry about it, and if I go on the pill, it will become regular. But I didn't want to go on the pill because I was worried about side-effects, so that's why we used condoms. So, the maximum days I waited for my period was like 44 days and after that I decided that something was wrong because it went to 50 days.

S: And you went for a pregnancy test?
P: Yes.

S: Portia, coming back to something you said, " ... it was the end of the world", what exactly is that feeling?
P: I didn't want to tell the people about it, anyone. And also, I was worried about how my life was going to work out. I don't know how to explain this feeling, but it was like I was not in charge of the situation, I didn't like the feeling ... umm, and I, er like I said, I was worried about my life, how it was going to turn out.

S: What were your concerns about what your life was going to be like, how your life was going to turn out?
P: I'm actually very successful in life and that would have been my first mishap, like they say, major mishap for me and the whole family.

S: How would your family have responded had you told them?
P: Ooh. [Laughs]. I think my mother would have kicked me out of the house.
S: So they would have been disappointed?
P: Yes, very disappointed. Something like this has never happened in our family, and they, er ... I'm like the hard-working one in the family, the responsible one, you can say, so that's why I think they would have taken it badly.

S: Ok, does that mean that you would not have been able to get any support from them?
P: No, I wouldn't. But he, I mean my boyfriend, was prepared to marry me. It's just that at the time I didn't want to get married. It would have felt too sudden, and we hadn't thought about it before. We hadn't discussed it before, so it was like a new thing. Marriage is a big step. I feel you must know exactly what you're doing, you must be ready for it and it must happen for the right reasons. So, it was like that. We didn't have any marriage plans and if the relationship didn't work, then I'd have to raise the child by myself. I don't think that I ... it would

have been very difficult for me, I felt more like a young girl than a woman in this situation. Although we'd been together for some time.

S: Portia, how old was this relationship?
P: It was a long relationship. We'd been going out for about five years.

S: Uh-huh. And how did your boyfriend respond when you discovered that you were pregnant?
P: We have a good relationship, so he was very supportive. We talked and he was prepared to go with whatever I wanted, you know, it was like that with us because, er ... I knew that I could depend on him and that gave me strength. He said that he would support any decision that I made and I felt no pressure from him either way. So I was lucky in that way.

S: Yes, you certainly were in that you had his support. Portia, I would like to know about your decision-making around the abortion. For example, ...?
P: You mean my other reasons, for example, er ... I mean, besides my family?

S: Yes, that's right, yes, your motivations in seeking an abortion.
P: Well, for one, I wasn't ready to have a child.
S: When you say you weren't ready, what exactly do you mean?
P: I was too young, at the time I felt like you can't suddenly become a mother. You have to think about it or plan for it and then you will feel more prepared to be a mother. Also, you need financial preparation, and I certainly couldn't afford to have a baby, not with my wages. I also contribute at home and we sometimes struggle to make ends meet. Even if my boyfriend supported me, we still wouldn't have managed financially because he also doesn't earn a lot of money. Also, like I said, we didn't have any marriage plans, so it would have been rushing things and that. So, I told him from day one that I didn't want a child and he told me he will think of something, that is, to organise the abortion, and that I must not worry it. It was either keep or terminate, and it was definitely terminate for me, so he organised it.

S: Portia, tell me about the abortion procedure, who performed it, how you found someone who was willing to perform it ...
P: Yes, ok. First, we went around to this one clinic in Khayelitsha, but they looked at me like they knew why I was there, although I didn't say anything to them. I was going to ask if they could help me, that is, er ... maybe refer me to someone, a doctor or a hospital or someone. But they looked scared to say yes or no or just talk to me about it. So I lost my nerve, and I said to my boyfriend, "Let's try something else, another option". At first we didn't want to ask the person he knew.

S: Your boyfriend knew someone who performed back street abortions?
P: No, not exactly. My boyfriend knew someone, a family friend, a nurse, and she gave him the name of a person who performed abortions. I cannot talk about who did it ... er ... well, it's a secret. But it makes me feel like I did something illegal.

S: I suppose the nature of back street abortion leaves women feeling that way.
P: Yes, exactly. Anyway, so I, we went to this lady's house after my boyfriend spoke to her on the phone. She said that she would do it, but that we must all be careful about not getting caught, because it's illegal. I was so pleased that we found someone to help us and quite quickly at that. She told me that she was going to induce the bleeding and after that I must go to hospital for a D&C, just to be safe, to make sure that it's all out. This person used a thin tube to start the bleeding and ja, er ... by that evening, I experienced some pain, almost like menstrual cramps, and I started bleeding. I went to the hospital and told the doctor that I had a miscarriage, and they performed the D&C. It was all fine after that. Fortunately, I was early, only a few weeks, maybe eight or nine or something like that. I hear that if it's later, you can have serious complications and some women even die as a result.

S: Yes, you're right. You were fortunate in that you did not suffer any physical after-effects. What about emotionally, how did you feel after the abortion?
P: Oh, after, I just felt so relieved that it was all over and that I could now get on. You know, that I didn't have to worry about this unwanted pregnancy anymore. But I also felt a little bit guilty because of what I had done. Or maybe I can put it this way, I feel ashamed about it, umm ... I know that I did something wrong.
S: In what way?

P: Because according to my religion it's a sin, it's like murder. Because life is very precious and by doing that, abortion, umm, you commit a sin, a mortal sin.

S: So it must have evoked some conflict for you because on the one hand you were in this situation, and you understood why you needed to have that abortion but there's also religion that says it's not on, it's a sin.
P: Definitely, ja.

S: Portia, have any of the feelings that you spoke about just now affected your life significantly?
P: No, just in the beginning, the first couple of weeks, but after, er ... I'll say that I'm living with it.
S: When you say that you're living with it?
P: It's fine for me. It's what I wanted for myself, so I made the right decision, umm, that's how it feels for me. It hasn't affected me negatively.

S: It sounds like you've coped well with it.
P: Yes, I think so.
S: What coping strategies did you use, what helped you to cope?
P: Well, my boyfriend, he helped me a lot because he was very supportive, he was by my side throughout the whole episode. That kind of support made a big difference for me. Also, he's the only person that knows about it. And what helped was being able to talk about it to him. I think that really helped. Not to keep it all bottled up inside of me but to share it with someone, with my boyfriend, that is. Yes, that's how I coped with the abortion.

S: So, support does help. And within yourself, what about yourself helped you in that situation, and also how do you normally deal with difficulties?
P: Yes, also myself. I think I'm a tough kind of person, strong and that helps me to deal with problems. Everyone in my family says that I'm a strong person. With the abortion, I didn't, er, I don't talk to people that are not involved in the situation. I rather just talk to him because he understands what it's all about. Also, people have very negative feelings towards abortion, so if you tell them, they'll be negative towards you and I can do without that.

S: And what about your own personal attitudes towards abortion?
P: Before I got pregnant I was against it, er ... because I suppose life is life. I mean that's what my religion says about abortion.
S: Ok, that was before. And now? Have your attitudes changed?
P: Yes. It's like this, you see. I think that if you're stuck with something you don't want, then that really is a problem. People are always telling you that you can put the child up for adoption and do this and do that, but they don't really know how it feels for the woman in the situation. And I know after it happened to me, so I'm not against it any longer. I know what
it's like for other women now.

S: All right. Portia, what, in your opinion, would help women in similar situations, and why?
P: I think it is important to be very sure before you do anything, you must be very sure before deciding because otherwise you may regret it afterwards. I'm sure that happens for some women.

S: So what would help women to feel clearer about what they want, about the abortion decision?
P: To think about it carefully, maybe to talk to someone about it. Umm, like your boyfriend or a close friend who understands. I think ... er, yes.

S: Do you think some form of counselling could help with what you've just described?
P: Yes, probably. Maybe counselling can help the woman to weigh her situation carefully, so that she's doing it for the right reasons and to help her afterwards if necessary.

S: In what kinds of situations would a woman need post-abortion counselling, do you think?
P: If she's crying and sad because she feels like she, like maybe her baby died or she lost her baby. Also, if the guilt is eating away at her. If the abortion affects her seriously, in a negative way. Does that answer your question?

S: Yes it does, thanks. Portia, is there any other information that you might want to share with me that will help me understand the abortion experience, what it's like for women like yourself?
P: No, I don't think so. I think that I've told you everything. I just want to say that I think that they should leave the decision to the woman.

S: I agree. Let's hope that the abortion law is changed soon so that women don't have to resort to back street abortions to terminate unwanted pregnancies.
P: I hope so too.

S: Well Portia, thank you very much for sharing your experience with me. I'd like to know, how was it for you, talking to me about the abortion?
P: Oh, it was fine. You're the only other person, besides my boyfriend, that knows about it now.

S: And thank *you* for that. I appreciate that this is something very personal for you.
P: Yes.

S: Portia, as I said initially, I would like to contact you again, once I have my results together. I'd like to share the results with you and to hear if I've interpreted your story accurately.
P: That's fine, we can meet again.
S: Thanks.

Name: Ferial
Age: 24
Residence: Southern Suburbs, alone
Marital Status: Single
Number of Previous Pregnancies: None
Number of Children: None
Years of Schooling: Tertiary
Occupation: Social Worker
Religious Preference: Islam
Psychiatric History: None

Interview:

S: Once again, thank you for agreeing to talk to me. Ferial, as I explained earlier, I would like to know about your abortion experience.
F: Can I start at the beginning? Or, umm, is that okay?
S: Yes, that's absolutely fine.
F: Well it all started when I got involved with this man ... I really liked him. We spent a great deal of time together. And for me, it was the first significant relationship in which I explored my sexuality. In that way he, er ... he was wonderful. I felt extremely comfortable with him. It was intense and passionate, just what I want from my sexual relationships. So it was like there was no place for whipping out condoms. [Laughs]. It doesn't explain why I didn't use something else. Maybe I got something out of it, like, umm, you know, it was exciting at the same time. I could live on the edge, ja, but nothing was going to happen to me.

S: And that's how you fell pregnant. Do you ...?
F: Uh-huh. I did not use any contraception. Sometimes I wonder if that was because a part of me unconsciously wanted to have a child and so I fell pregnant. It may very well be, umm ... I'm not quite sure.

S: It sounds like you have given this some thought. If there was a part of you that wanted to have a baby, then how did this impact on your decision to have an abortion?
F: I don't know, I just thought that it wouldn't happen to me. When I think about it now, I realise how foolish I was. How could I have thought that I was invulnerable when all around me women were having unplanned pregnancies? Umm, I'm not sure that I'm answering your question, but I guess I'm still trying to explain, er ..., I don't know, maybe I'm still trying to understand it for myself. I guess I also don't want to come across as just foolish and ignorant because that's not the whole story. My sexuality is an important part of who I am. And that's why some of it so difficult to make sense of. So even though I feel strongly about my sexuality and about taking responsibility for it, umm, I mean it was no less my responsibility as it was his, well, uhh, I didn't. So there's no excuse, I was simply irresponsible. But also he wasn't saying anything about contraception, and he'd been around, so I wasn't going to upset things. Sorry, Shahnaaz, you were also asking ...?

S: Yes, I was asking how all of this impacted on your decision making. What, would you say, influenced your decision to terminate the pregnancy, and how was that process for you?
F: Well, I wasn't sure what to expect when I went for the pregnancy test. When I phoned to ask about the results and they told me that I was pregnant ... umm, well I was surprised and I wasn't surprised. I just thought. "I cannot have this child". I was not ready to have a child. I was still busy discovering myself, umm, still maturing. I couldn't trust that I was adult enough to have this child. I guess I didn't want to take that risk.

S: Ferial, were there other reasons that came into play when you considered the abortion?
F: Yes. There were a few things. I can separate them now when I talk about it, but at the time it all felt like one big, er, one big ... muddled mass of anxiety about being faced with something that wasn't part of your life's plan for that time, if you know what I mean.

S: So it felt somewhat confusing and overwhelming?
F: It did. To start with there was the relationship. We had just met, it was a new relationship. Neither one of us knew where it was going and ... umm ... that was fine for me. But the pregnant put pressure on the relationship to either become something or to be able to hold a baby. And that's a major commitment. Really, we didn't know each other well enough to make that commitment, so ... umm ... yes, that also affected my decision. Also, my job. I guess I also didn't want to give up my job, it was new and offered potential, and of course I was hoping

to make a go of things, I was feeling excited about it because I had just started. You see, I am invested in making a success of my career, I see my myself and my career in that kind of way.

S: Ferial, did other peoples' responses influence your decision in any way? I am thinking particularly of your partner and your family.
F: My family! There was no way that I was going to tell them. Given who they are, they'd expect me to have a child within a marital relationship. Oh no, it would have freaked them out completely, major drama, umm ... and that would have been more stress for me. So I didn't tell them about the pregnancy and also about the abortion, of course. There was also the issue of religion and abortion to consider. From my religious perspective, it's not allowed. On that basis, my family and my community is vehemently opposed to it. But I feel differently. It's *my* body and it is *my* right to make decisions about it. I really feel strongly about that, you know Shahnaaz. Unfortunately, not too many people see it this way. Umm ... one's just got to listen to all this hoo-hah about abortion being murder and all of that. I just wish that these people and also the people who make the laws, men I suppose, ja ... I just wish that they'd listen to the women themselves 'cos it's so easy for them to jump onto this, er, to stand there and condemn us women. I really get angry, you know, 'cos it's a whole lot of academic and political bull-shit if you ask me. Sorry about the language, but you can see that I have strong feelings about this. There are so many women out there who just cannot afford to have that child. I know, because I see it in my work all the time.

S: Did this consideration affect you?
F: At the time it, umm, was not financially impossible to have the child. I had just qualified and had a good job. There would have been financial support from other quarters. But, I had this concern about giving up my financial independence and all that, ja ..., it meant to *me*. So what I'm saying is, I decided to have an abortion. My partner and I discussed it. He said that it was my decision and that he would support whatever decision I made. But I must tell you that it wasn't as simple as that for me, deciding to have this abortion. I don't know how to explain it. There were these feelings ... all right let me explain it like this. There was this feelings of events, significant events like issues around fertility and reproduction, had overtaken me and there was nothing that I could do about, umm, you cannot undo a pregnancy and it made me feel so, er ... impotent ... like this is it now, so deal with it. And I felt angry with myself in a way, umm, I think I blamed myself for the pregnancy because I had not been responsible with contraception knowing the consequences. But I also felt other things. When I found out about the pregnancy, I was distressed, concerned about what was going to happen because I had not planned for this, but in a way that was difficult to understand, I felt secret pride, umm, pleasure, I don't know what it was, it's difficult to explain except to say that it was a positive feeling.

S: Ferial, would you say that you were ambivalent about your decision?
F: Umm ... [Pause]. I'm really not sure. I'm just saying that it was not an easy decision to make. Although I do think, ja, I guess ... sometimes I fantasised about being a mother, even being somewhat of a family, that is, me, my partner and our baby. But, in the end it was something that I wanted to do, nobody forced me into the decision. And so I made all the arrangements feeling mostly like it was what I was wanting. Ja, I don't know if that answers your question.

S: Yes, it does, thanks. I'd now like to ask you about the actual abortion procedure and how went about arranging the abortion. Ferial, I'm also interested in knowing how this whole experience was for you.
F: Ok. Finding someone to do it wasn't a problem. One of my friends knew someone whose girlfriend had an abortion. He obtained the contact details from this friend and all I had to do was make the phone call. Umm, it was strange, this whole business of setting it up. It was, huh, yes it was strange. I had to speak in coded language when I called this woman, and she in turn spoke in codes. She indicated that she would perform the procedure at my house, umm ... for security reasons, it would be safer to do it that way. So she came to me and my partner was there with me and I had no idea what was going to happen. She didn't really tell me what she was going to do. All that she said was that she would induce bleeding and I was to go home and wait for the bleeding to start and then to go to hospital.

S: How did she induce the abortion?
F: She inserted this tube into my vagina and pushed it far up into my abdomen, probably into my cervix, yes I think so, and ... this was supposed to induce bleeding, well it didn't. I waited and I waited and still no bleeding. By now I wanted it to be over. You know, I hated that waiting, you have no control over what's happening. Well, I went back to her, umm, rather she came to me and ..., this time she wanted to dry out my uterus, whatever that means. This freaked me out, it sounded terribly unsafe and I didn't trust her with my body and really, my life.

I said, "No thank you", and I found a doctor who was prepared to do it. Of course she refused to refund my R2000. Umm, yes. My first attempt to induce cost me R2000, a whole lot of money, and the second attempt cost me slightly less. My partner and I shared the costs.

S: Can you tell me about your second attempt?
F: Like I said, when it didn't work with this woman, I found a doctor who was prepared to do it. I'm not sure if he was a G.P. or a gynae. Anyway, I was referred to him by ..., er, this time my partner made some inquiries and someone he knew told him about this doctor who performs back street abortions. So we tried him next. By now, I didn't want to waste time or beat about the bush. So I called him and I said quite directly that I was pregnant and that I wanted to have an abortion. He asked me to come to his rooms and that's where he did it. Er, if you don't mind I'm not gonna say too much about him. I feel loyal to the person who helped me. If he is exposed, he will not be able to help women like myself. But, umm also, although this is something else, I resent how all this makes me feel, it's like I'm a criminal. Er, is that fine?

S: Yes, I understand.
F: So anyway, first he did a scan, er, an ultra-sound to determine ho far I was, I think. I was about 10 weeks at the time. That was really something. It changed for me when I saw the picture from the ultra-sound. I did not feel anxious anymore, or uncertain, or umm, like I didn't know what was happening in my body. I don't know, I felt calmer. I knew now what I was dealing with. But you know, Shahnaaz, this also complicated things for me a whole lot. Now it was a baby, my baby, umm, and in that instant I wanted it, I wanted it so badly. I felt confused about my decision to abort, did I still want to do it? Umm, this was one of the most difficult moments in the whole process. Maybe this is what you were asking earlier, about ambivalence. This was a very tricky moment, but I must say that it wasn't as bad, umm ..., I felt shaken but not long enough for me to change my mind or to seriously consider changing my mind. It was mostly a fleeting, momentary thing.

S: It sounds like you're saying that the abortion decision isn't an easy one, whichever way you look at it.
F: Exactly. I think it's like that for most women. Er ..., yes, I was telling you about the doctor and what he did. He performed a D&C in his surgery. I was under general anaesthetic. But at some points I was vaguely aware of him working on my abdominal area, just here [points to abdomen], umm ... and at some point my eyes opened and I saw that he had all these instruments in his hands and there was blood everywhere. I could even feel some of the pain. The pain was severe, during and after. But there was no escaping it, you had to live with it because of the choice you made. Yep, that's how it happened.

S: And what was the doctor like, how did how relate to you?
F: He seemed to be pro-choice. He was understanding of my predicament and er ... I did not experience him as judgemental. In fact he was very supportive, he took me home after he was done. My partner had dropped me off there because the doctor said that he preferred it if I came alone. I would have liked to have had him there, my partner that is, but that's how it was. And I think the doctor knew that this set up was not ideal, and maybe he tried to make up for it, so he was supportive.

S: Ferial, how did you feel after the abortion? I'm interested to know what the impact of the abortion has been on you.
F: Well, I don't know, maybe ... a few things. Mostly, I felt relieved, the pregnancy was finally terminated. In the end I just wanted for it all to be over. It didn't help that the first time hadn't been successful. So, given all of that I was quite relieved. Immediately after the abortion, I just rested and took it easy, not that I was seriously ill or anything like that, but umm ..., it had been a difficult time and I guess I was just taking time out for myself, my body, everything. Putting it together, I guess.

S: What helped you to, as you say, 'put it together'? I'm also asking how you coped with the abortion experience.
F: Mostly, I knew, I know that I am resilient. Yes, I has some feelings about the abortion, and I felt like I had to look at these feelings, work through them and move on as best as I could. Also, my partner. His presence was very important to me. I needed him to be there for me, umm, to support me through this stressful time. I had supportive friends, but it's not the same as having your partner there with you, it makes you feel like you can do this and you'll be fine. So, I think, umm, putting it together was a combination of these things.

S: You have made reference to feelings about the abortion that you've had to work through. Can you be more specific?

F: All right. Yes, it was difficult. But I don't feel like I am this terrible person who has done this terrible thing, no, not as heavy as that. I certainly don't feel ashamed about it inside of myself ... umm, but I'm extremely aware of the fact that most people, certainly where I come from, are majorly anti-abortion, so they have very negative attitudes towards abortion. So I feel some of that because I can't talk about my abortion to others. I don't know if that's makes sense?

S: Yes, I understand what you're saying, it's about social disapproval and how that can impact on a woman's abortion experience.
F: Yes, that's it. There's also something else, I mean about what I felt afterwards.

S: Yes?
F: I felt some degree of regret after the abortion. Although it's what I wanted, ... umm ... I guess it's about the possibilities that I never explored, I wondered what it would have been like if I hadn't terminated. I have a feeling that being a mother would have been a meaningful experience for me. Sometimes I also felt a little bit of anger for the way it all worked out. I guess that's related to what I was saying earlier, that I was cross with myself for not being responsible with contraception. I think, if I had been, then this wouldn't have happened.

S: Do you feel sad now when you talk about it and remember it?
F: A little. A part of me feels like I gave up something that was a significant part of my life experience, a feeling like I could have had something. I thinks it's natural to feel some of that. But, it's not like I have been majorly traumatised by all of this. Like I said earlier, it can be tricky, er ... abortion is not a simple, straightforward business of terminating a pregnancy that you don't want.

S: Yes, that's what stands out for me as you speak. Ferial, given that this is how the abortion experience can be for some women, what do you think will help women in similar situations?
F: I think that counselling is crucial, umm, to help the woman to assess if she is making the correct decision, and if she is, to prepare her for it and to look at ways to help her cope with the experience. I don't think I have struggled as much as some women may after the abortion, so I'm lucky in that way. But, I think that women should be given the option anyway ... before and after. They can choose if they want to use the option, but they should be encouraged to because it can only help, especially for those women who don't have support. Also, if the woman is uncertain and confused or if she has mixed feelings about what she wants. I think then pre-abortion counselling can be very useful in clarifying things for her so that she doesn't feel afterwards like she took the wrong decision. It can prevent emotional problems.

S: What are your thoughts about post-abortion counselling?
F: Also useful, I think. It can help women to deal with their feelings in a healthy way. Some women ignore difficult feelings, but it inevitably catches up with them. So, to improve their emotional state, umm ... it can be helpful. I've also heard about support groups for women. I don't know if there are any here, but in other countries, I guess where abortion is legal, they provide opportunity for group-work. But, it may not work for all women. I don't think I would be too comfortable in a group set up, but that's just me. Other women may prefer it, so it's an individual thing. The point is, there should be those kinds of options anyway.

S: Ferial, you have shared a great deal with me. I wish to thank you for that. Before we stop though, I'd like to know how you feel about having shared your experience with me?
F: Well, I found it, er, useful to talk about this because it gave me an opportunity to reflect on things for myself. I find that that's how I tend to work things out for myself sometimes. Also, I'm pleased that I could assist in your research, I hope it's going to help to make things better for the women of this country, that is, on the abortion issue. And, thanks for listening to me.

S: Thank *you* for sharing your experience with me. I really appreciate that you made this time to talk to me. Like I said when we first spoke, I will contact you once I have my results together, to sound it out with you. I'd like to know if the results are an accurate reflection of your experience as you told it to me today.