WOMEN'S EXPERIENCE OF ABORTION - A QUALITATIVE STUDY

Thesis submitted in partial fulfilment of the requirements for the Degree of Master of Social Science (Social Work), Rhodes University, East London.

by
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December 1997

CONTENTS

ACKNOWLEDGEMENTS

My thanks go to:

The women who participated in this study for sharing their stories with me. I am privileged that they felt able to share the intimate details of their pain and learnings with me. My wish for them - and all the other women who have had abortions - is that they be gentler with themselves.

My supervisor, Felicity Coughlan, for her guidance and support and the veiled warning, when I had stalled due to work pressure, that I would have to accept that I would have to re-register for another year. It was just what I needed to hear.

My Master's colleagues and lecturers for their warmth and friendship and for making our two years together such an enriching experience.

My special friends, Andrea Bryce and Tanya Jonker, for their constructive criticism and proof-reading skills but mostly for their love, support and encouragement; and Lucinda Moonieya for her typesetting, layout and computer skills.

Finally, I would like to thank my family for giving me the time and space to complete my work and for putting up with my tetchiness during trying times and deadlines.

DEDICATION

For all unborn children, their parents and grandparents.

There are some griefs so loud
They could bring down the sky,
And there are griefs so still
None knows how deep they lie,
Endured, never expended

(Sarton in Nathanson 1990: 10)

ABSTRACT

Abortion is an emotive topic that always raises strong feelings. The purpose of this study, however, is not to focus on the religious, political or moral questions surrounding abortion. Abortion is a reality and in South Africa, where it has only recently become legal, there is a need to have an understanding of the effects on women in order to provide counselling services. There is also a need to provide services for the many women who have had illegal terminations in the past. This study reviewed the most recent literature on the subject and the researcher takes the view that although the scientific literature states there is little long term psychological effect of abortion, the non-positivist literature which records women's experiences tells another story. Some of the problems with the scientific literature is that psychological effects are not defined and there may be political motivation for the study ie. an attempt is made to prove that the health costs are not high for abortion because there is little long term effect. The researcher, however, feels this does a disservice to women who have had abortions because there is a failure to provide counselling services. Some members of the feminist movement also deserve criticism because in their haste to give women their rights they fail to allow a woman to thoroughly explore her options beforehand and to provide support services afterwards. The researcher, however, also identified a new theme in the literature which has been called a maturing of the feminist viewpoint that along with the right to abortion, women also have a right to the mixed feelings that go with making, what is for many, a very painful decision. There is a recognition that abortion is about loss and thus there is a corresponding need to acknowledge women's need to mourn and to provide services. The study does not include the experience of women who seek abortions for reasons of poverty. It also excludes the experience of women who have abortions as a result of rape, incest or harm to the foetus. It is a qualitative study and a non-probability sampling technique which comprised snowball and purposive methods was used to identify respondents. In-depth semi-structured interviews using a broad theme of questions were conducted with five respondents. The women were asked to tell the stories of their abortions: their and their partner's feelings before and after, how they decided and the actual experience. They were also asked to identify counselling requirements, what they found helpful and what would have helped. The literature and the findings support the researcher's view that women who find themselves with an unexpected pregnancy need an opportunity to objectively consider all their options, namely keeping the baby, adoption or abortion, and to have an objective counsellor assist them in vigorously considering these. If they decide on a termination they need to be given as much information as possible about the procedure and about how they are likely to feel. Afterwards counselling should be made available and women should be encouraged to use the service. They need to be assisted to explore all ways of coming to terms with it such as through dream work, dialogueing with the unborn child through a letter and for those with religious beliefs seeking absolution from the church. There is a great need for a Christian and other religious ministry in this regard. Self-help therapies such as support groups can also be helpful.

Oh what despair
the pain I bear
as lightning flashes
thro' my heart
and thunder echoes
in my mind

I aimlessly roam
lost and alone
as my eyes no longer focus
and my ears remain deaf
to the piercing screams
of my soul

Another day dawns bright
victorious over the night
and I want to spit
at the sun for shining
when my day looms ahead
grey, dark and forlorn

My light has gone away
and tho' I know that it may
one day shine for me again
for now I am content
to hide alone
in my gloom

Closeted I'll remain...
behind drawn curtains
and locked doors
for, outside
lives the world
and I cannot be a part of it
right now

(Mary)

CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

This chapter will give a brief overview of some of the main issues relating to abortion[1] as it pertains to the title in order to introduce the complexities of the topic and explain the purpose of the research. A review of current literature on abortion follows in Chaper Two.

There is a great deal of emotional dialogue about abortion but few women speak openly about the actual experience of terminating a pregnancy, namely the decision making process and the feelings before and afterwards. It is a taboo subject as far as it affects people personally.

Davies, (1991: 13) an English psychologist who had an abortion in 1988 and who has written a comprehensive self-help book, states that significant to the extent of this taboo, the majority of letters she received were sellotaped and marked private and confidential. Many women chose not to put their names and addresses, and all but two wished to remain anonymous. Neustatter (1986: 103) found her subjects had not spoken about their experiences before and said this gave some indication of how powerfully the taboo silences women. This secrecy is not only indicative of a strong taboo but it gives an indication of the possible feelings behind the behaviour: unresolved pain and loss, a fear of being judged, anger, shame, guilt and regret.

The significance of this is that there are many women worldwide who undergo abortions every year but who may never have had the opportunity to work through their feelings and to mourn their loss. There is thus a very real need for opportunities to be created to provide this service and for social workers, psychologists, health workers and other professionals who come into contact with women who have had, or intend having, an abortion to have a thorough understanding of the complex issues and emotions at play in order to intervene effectively. There is also a need for counsellors to explore past pregnancies in the course of ordinary counselling, as many women do not associate present difficulties with a past abortion (Davies 1991: 16; Dillon 1990: 13: Winn 1988: 7).

An American psychologist, Nathanson, (1990: 6) who had an abortion after she had three children, says for her, mothering, like hunger, is a primordial instinct that begins to function automatically at conception, "consequently I felt the abstract potentiality of the fetus[2] as a tangible

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1. Abortion/termination. These terms will be used interchangeably to avoid repetition and to improve readability.
2. Foetus/fetus. The concise Oxford dictionary uses the spelling foetus but South African legislation refers to fetus. Both spellings will be used where appropriate.

reality". She says she experienced a crisis of soul - unlike any other experience of suffering she had encountered.

> Soul crisis is my name for an experience that consists of much more than an intense emotional reaction to loss and trauma. It involves the shattering of one's beliefs about oneself and one's life into fragments that cannot be put back together again in exactly the same way. It is an experience that forces an assessment of one's basic mode of being in the world, that compels the examination of familiar assumptions, that requires the loss of innocence and a simple worldview, that demands the rebuilding of one's basic foundations (Nathanson 1990: 6).

Nathanson's (1990) personal account of her road to healing offers valuable pointers to counsellors as does Davies (1991) whose view is that "even though the event may have caused pain and turmoil, and will for ever be a part of us, we need not be hurt permanently by it, we may even be able to gain something from it. We can grow, not just cope" (1991: cover).

It is difficult to arrive at reliable estimates of the numbers of abortions performed in South Africa before abortion was made legal this year because these were coloured by who was using the data and for what purpose. Rees (in Jagwanth, Schwikkasd & Grant 1994: 243) says there were 1 000 legal abortions performed annually and between 42 000 and 300 000 illegal abortions but states that the search for reliable figures was complicated by the fact that the wealthier woman was able to travel overseas for a legal abortion while disadvantaged women resorted to the "back-street" option. The Reproductive Rights Alliance says of these, an estimated 43 000 women were hospitalised from medical complications (Daily Dispatch 24 October 1997: 12). Adler, David, Major, Roth, Russo & Wyatt (1992: 1198) note that the trauma is likely to be greater if the abortion is procured illegally. In the first six months since abortion has been legal, 13 000 terminations have been performed according to the Reproductive Rights Alliance. Two thousand of these have been in the Eastern Cape (Daily Dispatch 24 October 1997: 1).

Abortion was legalised with few services in place and thus there is an added urgency to address the question of counselling and establish what women's needs are. The new legislation in South Africa and its implications is outlined in the context of the need for pre- and post-abortion counselling under section 1.9. Although counselling has not been made mandatory, workers in the field of service provision need the necessary skills and a thorough knowledge of the dynamics involved to offer help and to be pro-active in doing so. The reasons for this will become clear in the review of the literature in Chapter Two. This process will probably be hampered by opposition to the procedure by health workers in the field (Mail and Guardian 7-13 February 1997: page unknown) but if there is a greater understanding and publicity surrounding the effects of abortion, it might lead to a more compassionate approach. Haslam (1996: 10) notes that much of the emotional pain that is suffered by those who undergo abortions is greatly aggravated by those who set out to condemn.

The researcher is aware that using the phrase "mourning the loss" is contentious and also problematic because the reader, in trying to assess whether the researcher is for or against, will almost immediately label the work as being in the latter camp, and, depending on their viewpoint, be sceptical of the conclusions. This thesis is not about the researcher's moral, ethical, political or religious views on abortion, rather its aim is an attempt to establish a suitable counselling framework to help women and provide them with emotional support. It is also contentious because those who support a woman's right to choose tend to use emotionally distancing words such as foetus, cluster of cells and so on and hence talk of loss may be dismissed as being incorrect. The researcher is of the opinion that no matter what a person's standpoint is about when life begins - be it at conception or when the foetus becomes viable - the nub of the issue for many women is the potential life and the loss of that potential life that causes the pain and feelings of loss.

Dillon, (1990: 12-13) an American Catholic priest, whose book is aimed at "parents of aborted children and those who minister to them" (1990: subtitle), quotes an obstetrician and psychiatrist, Dr Julius Fogel, on this point:

> Every woman - whatever her age, background or sexuality - has a trauma at destroying a pregnancy. A level of humanness is touched...There is no way it can be innocuous. One is dealing with the life force...it is not as harmless and casual an event as many in the pro-abortion crowd insist. A psychological price is paid (in Dillon 1990: 12-13).

Neustatter (1986: 108) quoting a case history also refers to this:

> There is no way of avoiding the issue of an abortion being the termination of a potential human life and the feelings that this brings up for you. It is precisely these feelings that are denied by the current liberal view of it as being a minor event (1986: 108).

While the above viewpoints may be contentious they illustrate the possible dimensions of the experience.

It is also important to recognise that for many women this is the case, not to use it to advance one's political argument, but to ensure that counselling services are available. There are numerous factors which influence the level of trauma as each woman's circumstances are unique and this will be addressed in depth in Chapter Two.

Although some researchers have found no serious harm to women's health or mental well-being

as a result of abortion (Adler et al. 1992: 1194), leaving aside the debatable merits of the methodology and political motivation of these studies, and the problem with what exactly is meant by psychological harm, there is sufficient evidence of women's suffering and that alone is sufficient reason for professional counselling to be provided. That there is a need for counselling, self-help and support groups is thus considered indisputable.

1.2 OBJECTIVES OF THE RESEARCH

The goals of the research are:

a. to gain a deeper understanding of the range of feelings and dilemmas associated with abortion - in the decision making process and afterwards;

b. to obtain a perception of the role and effect of counselling or lack thereof;

c. for women to identify what would be important for pre- and post abortion counselling; and

d. to identify other avenues of help and support such as self-help groups, groupwork and so on.

This will enable the researcher to arrive at some type of framework that can be used to work effectively with women who have had abortions.

Secondary objectives are to :

e. create a greater understanding of the complexities of the issues in the hope of generating more insight, understanding and empathy from those who would condemn; and

f. attempt to prevent a misguided simplification of the issues involved which results in a disservice to those who have abortions by those who support their choice.

1.3 ANTICIPATED VALUE OF THE FINDINGS

a. The researcher wants to find the most effective means of offering help in terms of support services. This will be achieved by gaining an understanding of the range of emotions a woman may face when she finds herself with an unplanned pregnancy; and by considering the pain, guilt and loss that often results from abortion.

b. Any piece of work that can contribute to a greater understanding of this taboo subject will be useful because there is a dearth of literature on women's experiences and what their counselling needs are.

c. Based on the findings, the researcher will also make tentative recommendations about where the services should be offered and by whom.

d. Dissemination of findings through appropriate professional and public media.

1.4 SCOPE AND LIMITS OF THE STUDY

The sample is a small one consisting of five respondents but the interviews are in depth and the researcher is satisfied that, in view of the fact that the findings are supported by the non-positivist literature which focuses qualitatively on women's experiences, the findings are reliable and valid for these women and the many others who experience feelings of pain and loss after an abortion. It is beyond the scope of this research to focus on women who cope relatively easily after an abortion but I accept that many may do so. However, I maintain that this is possibly overemphasised in some quarters for political, financial and feminist purposes.

Miles and Huberman (1996: 10), in discussing the strengths of qualitative data, speak of its richness, holism and flexibility, and say that it has strong potential to reveal complexity; it provides "thick descriptions" that are vivid and have a ring of truth that has a strong impact on the reader.

1.5 RESEARCH DESIGN AND METHODOLOGY

1.5.1 Scope of the investigation

This is a qualitative study as this type of research lends itself to investigating deeper meanings of human experience (Rubin and Babbie 1989: 364).

1.5.2 Research tools

The study comprises semi-structured in-depth interviews of open and close-ended questions. The literature informed the questions asked and has identified the major trends.

Therefore, in order to establish the nature of counselling needed the themes of questions incorporated the following:

a. How long ago did you have the abortion and how old were you at the time?
b. The nature of your relationship at the time.
c. Your feelings and those of your partner when the pregnancy was discovered.
d. Making the decision.
e. Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?
f. The abortion itself.
g. Your feelings afterwards, immediately; several years later; after having children.
h. Did you have any type of counselling before or afterwards?
i. What was useful and what was not?
j. What would have helped?
k. Who else knew/did you talk to?
l. Did you/do you have any religious or moral views on abortion before the termination or after and did these change?
m. Did your feelings about having children change after the abortion?
n. What would you say to someone seeking an abortion?
o. Would you have another abortion?

It is important to note that the questions regarding feelings were only asked after the initial information was obtained in order not to provoke feelings that may not have been present to start with.

The interviews took place by mutual arrangement with the subjects in private venues to ensure confidentiality.

There was no pilot study for several reasons. As this is a small study comprising in depth interviews on broad themes of questions, the potential for problems is less than in a quantitative study comprising questionnaires where the rules of drawing up questionnaires comes into play. Problems such as providing insufficient alternatives to close-ended questions, for example, could be checked by conducting a pilot study (Hall and Hall 1996: 127). From my understanding of the literature (Dooley 1995; Hall and Hall, 1996), a pilot study is most often used with quantitative research.

I also believe a pilot study is potentially unethical in a qualitative study of this nature because of the researcher responsibility to the respondent in terms of using the data collected. Part of the explanation to draw people into the study was that their shared experiences might assist other

women and lead to better counselling facilities. If, in the interests of conducting a pilot, the information is then discarded, I believe the ethics involved are dubious. Dooley (1995: 350) says the purpose of a pilot test is to determine effectiveness before using it for the main study. I believe an extensive survey of the literature is adequate for a sensitive topic such as this.
In addition, I used a system of checks and balances, whereby the transcribed interviews were referred back to the respondents for checking and additional information was sought in subsequent follow-ups. Supervision was also essential to this process.

For a more detailed explanation of the research tools and the problems experienced with it please see Chapter Three.

1.5.3 Analysis of data

The interviews were taped and transcribed. In keeping with qualitative data, the analysis sought general trends (Rubin and Babbie 1989: 353-354). The authors speak of looking for similarities and dissimilarities, patterns of interaction and events that are generally common, being "attuned to universals" and also differences. In addition, the subjects were asked what was and was not useful in terms of counselling in order to aid the production of findings.

The analysis will be fully discussed in Chapter Three.

1.6 PROBLEMS EXPERIENCED WITH THE STUDY

There were no major problems with the study except that I kept questioning myself regarding my own biases. Rather than this being a weakness, however, I believe it was a strength because it kept me alert to overemphasising one viewpoint over another and assisted in maintaining balance.

The interviews were more detailed than first anticipated but I believe this enriched the process rather than detracted from it. Rubin and Babbie (1989: 364) point out that quantitative methods are concerned with maximising objectivity and testing validity, whereas qualitative methods are concerned with "subjectively tapping the deeper meanings of human experience".

1.7 PROBLEMS EXPERIENCED WITH THE LITERATURE

There are several problems with most literature on abortion. There are two viewpoints on the topic with the semantically problematic labels, pro-life and pro-choice, and most people fall into one of these categories. Pro-life is a self-proclaimed term used by various groups who oppose abortion. They are also called anti-choice by supporters of abortion (http://www.gargaro.com/lifem.html). Pro-choice is the term used to describe those who support a woman's right to choose to have a termination or carry the baby to term. Both are problematic because in general terms the former implies people who support abortion are against life and people who oppose it are

anti-choice. The labels are emotive and loaded but they do serve to provide a quick indication of a person's viewpoint. Thus, when reviewing the literature it is essential to consider the ideological motivation, and political bias of the author. Adler et al. (1992: 1197) say several authors (Adler 1979; Dagg 1991; Illsley & Hall 1976; Simon & Senturia 1966) have identified ideological and assumption-based biases in the abortion literature. Often both sides employ a selective choice of corroborating information (Speckhard 1987 in Adler et al. 1992: 1197) and ignore or minimise opposing arguments. Rue (1995: 26) also notes that "in the emotionally charged public debate about abortion, overstatements abound" and cites Mann (in Rue 1995: 26) who says "it is psychologically devastating to most", and Stotland (in Rue 1995: 26) who says there is no evidence "whatsoever of any post-abortion trauma".

There is, however, a new trend that is beginning to emerge which has been called a "maturing of the feminist view" (Lodl, McGettigan & Bucy 1985: 121) and that is that choosing an abortion is not an easy decision and there are mixed feelings involved for most women. Neustatter (1986: 37) says abortion is being re-examined as a subject where women's feelings are important alongside their rights.

This is how one woman described her mixed feelings:

> I decided to have an abortion, but I didn't like myself for doing it, I didn't feel good about it and the fact that I was exercising my right to choose did not heal the pain I felt at having ended a life (case history quoted in Neustatter 1986: 38).

The non-positivist literature written by or about women who have had abortions (Davies 1991: Nathanson 1990; Neustatter 1986; Winn 1988) tells of, among other things, the pain and loss of abortion. On the other hand quantitative research studies by psychologists tends to minimise the effects. For example, a recent study (Adler et al. 1992: 1198) states that while women may feel a mixture of positive and negative emotions after an abortion, the most frequent response is that of relief and happiness. They, do, however, concede that the long term effects are uncertain and that women who find abortion more stressful may be under-represented in their sample (Adler et al. in Rue 1995: 16). I believe that the aspect of relief has also often been misrepresented in the literature because as Dillon (1990: 3) notes women do initially, experience some kind of relief but not a feeling of joy or gratitude, rather relief that the experience is over.

I believe quantitative methods of investigating women's experience of abortion are inadequate as they do not have the "thick descriptions" that are vivid and have a ring of truth that impacts strongly on the reader and which is found in qualitative data (Miles and Huberman 1996: 10).

The non-positivist literature is powerfully convincing in its human dimension: women's responses are not reduced to statistics, rather they speak with a great deal of emotion about their experi-

ences. It is also my experience in dealing with women who have had abortions that there can be profound effects.

While struggling with these contradiction, it became clear to me that trying to prove either argument is both difficult and unneccessary for the purposes of this topic. There is sufficient evidence to motivate for counselling services simply by reading women's self reports and other available literature (Davies 1991; Dillon 1990; Nathanson 1990; Neustatter 1986; Winn 1988).

In addition, even if one accepts that it is the minority of women who have long term problems, even a small percentage of the large numbers of women who have abortions - an estimated three million in the United Kingdom since 1968 (Haslam 1996: 228) - adds up to a big need.

Rue (1995: 26) says given the methodological weaknesses in the available literature, the large variety of existing studies, and the supporting clinical evidence, "any statements concerning the psychological safety of abortion are premature, misleading and harmful to women's health".

I believe part of the problem revolves around the term psychological damage and what is meant by it specifically. This needs to be made clear. Adler et al. (1992: 1202) refer to a study from Denmark in which psychiatric hospital admissions were tracked three months post abortion and post partum for all women under the age of 50 residing in that country. The study found that among women who were never married and women who were currently married (who represented the majority of women) the post pregnancy risk of admission to a psychiatric hospital was about the same for abortions or deliveries namely 12 per 10 000 versus 7 per 10 000 for all women of reproductive age.

The nature of the pain described by women writers, however, does not indicate the presence of the type psychopathology requiring hospitalisation and the problem may be "minuscule from a public health perspective" (Koop in Adler et al. 1992: 1202) in terms of costs - although this is debatable in terms of the provision of counselling services - but it does not under-emphasise the level of suffering that may be felt.

Adler et al. (1992: 1196-1197) refer to the two broad types of theoretical perspective underlying research namely the one that focuses on psychopathological responses following abortion; and the other which sees it in terms of normal stress and coping. From this perspective abortion is seen as a potentially stressful life event that poses difficulties but does not necessarily lead to psychopathological outcomes. Rather a range of possible responses, including growth and maturation, as well as negative affect and psychopathology, can occur. I believe these categories do not cover the issue of loss, and that the pain that many women experience, is related to loss and the cycle of grief that goes with it. There may also be guilt, regret and a range of other emotions.

Miller (1992: 81-83) looks at psychological consequences of abortion and says there are five models. These are as follows: the stress model on which the outcome is based on risk factors; the norm violation model in which social norms cause the negative reaction in women; the loss model where there is childbearing ambivalence and coercion resulting in grief; the decision model in which the decision-making process and situation constraints affect outcome; and the learning model in which anxiety and insight operate and result in behaviour and relationship changes. These theories do have merit in that all these aspects do affect coping outcomes but what they overlook is the reality that essentially the issue is about the loss of a potential life. In addition, I believe aspects of studies (Miller 1992) which attempt to assess women's feelings a week post-abortion have little worth. If they were to have any merit, variables such as denial as a coping mechanism and post-partum blues caused by the normal hormonal fluctuations associated with pregnancy, would have to be taken into account.

It is important to note that while many women relate their experiences in the hope of helping other women, the pro-life lobby use these same experiences to advance their views. It is interesting to note that both sides of the debate are beginning to call for a rethink but they have different ways of addressing this. The thread of argument running throughout the work edited by Doherty (1995) is that there is a need for a rethink on abortion because of the long term effects on women's health. Lodl et al. (1985: 121) say abortion counselling agencies in the United Kingdom are beginning to re-examine the idea of providing post-abortion services as a mainstream service area.

While acknowledging that many women may have a limited adverse experience this research is focused on the experiences of those who do require assistance or who do have negative experiences and reactions. As a result of this focus the apparent bias in literature is a deliberate effort to focus on the issue at hand and it in no way seeks to obscure the existence of other perspectives.

1.8 DEFINITIONS OF THE CONCEPTS

1.8.1 Abortion

By abortion the researcher means an active termination of pregnancy by removing the foetus from the womb (Winn 1988: 215) as opposed to a spontaneous abortion which occurs initially without medical or other intervention.

The dynamics of abortions procured because of a malformation of the foetus, as a result of rape or incest and late abortions are different to those associated with the above and have been excluded due to the small sample and limited nature of this research.

Haslam (1996: 8) prefers to use the term termination because he says abortion is a confusing and emotive word. Abortion is also the technical word for miscarriage and he believes it is outdated. The researcher believes termination may be the more appropriate word to use in counselling as it displays more sensitivity but that the terminology used by the respondent should be the guide.

1.8.2 First trimester; second trimester

The first three months of pregnancy; the mid three months of pregnancy.

1.8.3 Foetus/fetus

The developing life after eight weeks of conception is known as a foetus (The concise Oxford dictionary 1983 sv "foetus")

1.8.4 Post abortion syndrome (PAS)

There is debate whether or not such a syndrome exists but those who argue that it does, such as Dillon (1990: 9-11), state that PAS is a diagnostic term being used by more and more professionals to describe a wide range of symptoms that are intimately related to, and are expressions of, a previous experience of abortion. It is a clinical way to understand what seems to be occurring in those who have directly or indirectly experienced the termination of life of an unborn child. PAS finds its origin in the continual denial, repression or rationalisation of thoughts or feelings to the point where these unresolved emotions, which are not being dealt with in a healthy way, begin to exhibit themselves in a number of symptoms. The symptoms are masks that both express and hide the real difficulty underneath - unresolved guilt, grief, regret and loss. Dillon (1990: 10) says PAS can best be understood in the context of post traumatic stress disorder (PTSD), a category of the Diagnostic and Statistical Manual of Mental Disorders (DSM III). Post traumatic stress is a reaction to an event or series of events that are outside the range of usual human experience. He says this is an important consideration. He says simply because abortions are done so frequently does not mean they are normal by physical or emotional standards. Rather abortion is a traumatic event that needs to be recognised, resolved and healed. A description of the "symptoms" of PAS are provided in Chapter Two as a useful reference because many women experience and exhibit many of the feelings and behaviours associated with PAS, but some writers do not label it PAS.

1.8.5 Unplanned/unwanted pregnancy

Haslam (1996: 11) says perhaps the best description of the pregnancy that ends in termination is that it was unwanted. He says it might have started as a planned pregnancy - so the term unplanned is not suitable. On the other hand unplanned pregnancies may frequently turn out to be

wanted once the surprise or shock has died down. Even the term unwanted may cause an ambivalent mixture of confusing feelings. A case history challenges this point: "We desperately wanted to keep the baby...but I finally decided it was not possible because of financial difficulties and a lack of security for myself or the child" (Davies 1991: 45). Another case history illustrates the problem further: "I said I didn't want to bring an unwanted child into the world and he said 'It's not an unwanted child; it's an unwanted pregnancy'. That was the most helpful thing anyone said" (Neustatter 1986: 62-63). I prefer to use, where possible, the term unexpected.

1.9 NEW SOUTH AFRICAN LEGISLATION

The Choice of Termination of Pregnancy Act, 92 of 1996, which came into effect on February 1, 1997 states that a pregnancy may be terminated under the following conditions:

- upon request during the first 12 weeks of gestation;

- from the 13th up to and including the 20th week of gestation if a medical practitioner is of the opinion that:

- the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

- there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

- the pregnancy resulted from rape or incest; or

- the continued pregnancy would significantly affect the social or economic circumstances of the women; or

- after the 20th week, if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy:

- would endanger the woman's life;

- would result in severe malformation of the fetus; or

- would pose a risk of injury to the fetus (The Choice of Termination of Pregnancy Act 92/96 Sec 2(1)).

With regard to counselling the Act stipulates that the State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy (Sec 4)

The Act states that in the case of a pregnant minor, a medical practitioner or a registered mid-wife, shall advise the minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated. Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them (Sec 5(3)).

1.10 ORGANISATION OF THE STUDY

The thesis is set out in the following manner:

Chapter Two: is a review of the literature on abortion over the past 10 years. It covers books, journal articles, unpublished theses, conference papers, and newspaper and magazine articles. The researcher also accessed the Internet in search of current counselling techniques.

Chapter Three: contains a discussion of the methodology and research design that has been used.

Chapter Four: is a presentation and discussion of the findings

Chapter Five: presents conclusions and recommendations for counselling and suggestions for further research.

Finally there is a complete bibliography of sources followed by appendices which include the transcribed interviews.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will review the literature on abortion that has been published in the past 10 years as well as some information taken from the Internet. The main focus of the discussion will centre on women's experience of abortion; the feelings associated with it and the type of counselling that is required to meet the needs of women before and after terminating a pregnancy. Where possible the format will follow that of the interview questions.

The discussion will not explore the opposing views on abortion or the political or religious context of the debate other than to refer to it as it impacts on the topic. I do not consider it necessary to go into this because this research is not about that particular debate, it is about the need for counselling to be provided for women before and after an abortion.

The core texts I have used are the non-positivist literature written by women about their and other women's experiences of abortion and I consider these to be ground-breaking because of the relative rarity of the detailed recording of women's stories. The two other core texts are by a British doctor and a Roman Catholic priest. In the latter, the underlying theme is one of compassion and although this type of ministry is specialised in terms of the spiritual aspects of healing, the book contains important insights for counselling and highlights the need for an awareness when referral may be necessary. There is a range of sentiments expressed in the literature that has been reviewed that covers the spectrum of opinion on the subject.

2.2 DISCUSSION

2.2.1 Feelings

a. Overview

Winn (1988: 111) says it is neither possible nor desirable to generalise about the experience of abortion. Nathanson (1990: 5) agrees that women vary in their feelings about it before and after. "But it can help very much to know that any or all of a whole range of reactions are natural and normal and, by sharing in the feelings of others, it is possible to feel less alone with one's own" (Winn 1988: 111).

Davies (1991: 13) says all the women, and men, she had contact with shared, for the most part "a highly distressing and painful experience" and shared their experiences for two reasons namely that it was the first time anyone had asked them about their feelings and wanted to listen; and in the hope it might help other women cope".

The non-positivist literature states that there are a whole range of feelings that can predominate such as grief, sadness, and guilt (Davies 1991: 120; Winn 1988: 75).

b. Life-changing crisis

Davies (1991: 15-16) says most women feel abortion has a profound effect on them, their relationships with others and their entire lives. A few weeks after she had an abortion she became "destructive and emotionally unstable"; unable to forget or come to terms with what happened. She described it as the "worst crisis" of her life (Davies 1991: 13). Nathanson (1990) titled her book Soul crisis and spoke of other women who like her, had been "catapulted into whirlpools of emotional pain" after their abortions (1990: 4). A British abortion counsellor, Caroline Bailey, quoted in Neustatter (1986: 90) describes it as "a very real life crisis - the one death you know in advance is going to happen". As Nathanson (1990: 2) puts it, once a new life has been conceived, there is no turning back; "an unalterable event - physical and psychological - has occurred".

c. Mixed feelings

Neustatter (1988: 12) says women who support abortion are not free from personal conflict and quotes feminist Kathleen McDonnell who describes the unexpected, ambivalent feelings she had after the birth of her daughter. "There is a realisation emerging that abortion hits us at the very core of our female socialisation." It is an historical juncture where women are faced with unprecedented choices for which history and conditioning have ill prepared them.

> "The entrenched opposing arguments, which are battled out in the political arena, make abortion appear simple in a way that women individually, do not experience it." (Neustatter 1986: 27)

Neustatter (1986: 1-2) describes her own confusion saying she had always marched and campaigned for a woman's right to choose but when it came to deciding to end her pregnancy she was shocked at the distress and confusion she felt. She felt intensely sad and had a "curious upheaval of emotions". The theme of mixed feelings accompanying rights is also described by Winn (1988: 43) and Haslam (1996: 60) who cites a case history in which a woman was thankful she was given permission to grieve.

Neustatter (1988: 4) says her subjects reveal complex emotions and tell "the human dimension of abortion". She says relief may be interwoven with a profound sense of loss and guilt at the irrevocability of what has been done. One woman cited in Neustatter (1986: 91) described a common feeling when she said: "I realised once it was over that I didn't like myself for what I had done...I felt flawed; I had this strong sense...people could see what I had done and that they would be judging me as bad" (Neustatter 1986: 91).

Neustatter (1986: 3) notes that because the politics of abortion are so heated, discussion of feelings about the experience tend to be used to "propagandize and make points". Nathanson (1990: 5) says this means that there is little attention left over to meet the needs of the women facing the dilemma. Neustatter (1986: 110) says the pro-choice lobby needs to acknowledge that ambivalent, distressing feelings are a legitimate part of the experience and in no way undermines the importance of allowing women who feel they need an abortion to have it with the minimum of trauma.

Davies (1991: 15) says unwanted pregnancy, miscarriage, ectopic pregnancy and deformed foetuses are part of womanhood and cause feelings that include guilt, self-blame, swings of emotion, depression, grief and a deep sense of loss. She argues that women who choose abortion should not have to forfeit their right to speak out, grieve and be understood.

d. Unresolved feelings

Dillon (1990: 8-9) says unresolved emotions are common and a social environment that does not allow people to work through their emotions often causes them to bury the thoughts and feelings associated with the loss. Dillon (1990: 3) says a growing number of people are saying they are hurting because of their decision to abort and while it initially relieves stress and anxiety, it is now being seen as a cause of stress and anxiety: "a traumatic experience whose destructive elements remain for months, often for years" (Dillon 1990: 3).

Dillon (1990: 4-5) refers to "abortion's second victims, the children's parents who go on living" and says actress Gloria Swanson permeated her entire autobiography with the memory of an abortion she had at the height of her career: "The greatest regret of my life has always been that I didn't have my baby...Nothing in the whole world is worth a baby. I realised it as soon as it was too late and I never stopped blaming myself" (Swanson in Dillon 1990: 4).

Other actresses, Patricia Neal and Shelley Winters, also express regret. Neal (in Dillon 1990: 4) said she cried for over 30 years. "If I had only one thing to do over in my life, I would have that baby". Winters (in Dillon 1990: 4-5) also "would give up everything...if only I could have those children now".

e. Religious viewpoints

It is important to note that the opinions of Dillon that follow may be vociferously opposed and argued by some but his views are important because in a new study a comparatively high percentage of women (18 per cent) who have abortions identified themselves as born-again or Evangelical Christians (Daily Dispatch 9 August 1996: page unknown). Thus, in terms of coun-

selling needs, it is vital the Christian and, indeed, all other religious viewpoints, be accommodated. Although it may be beyond the training of the social worker or other helping professional, it will be important to identify the need in order to refer the client.

Dillon (1990: 29-30) says spiritually many see abortion as their first serious sin and the one that is unforgivable by God. Many interpret subsequent difficulties or hardships as "God getting me back". Some authors (Blacker 1995: 47; Casey 1995: 80) speak of the consequences namely a reduction in religious activity or inability to pray and see the abortion as "letting God down".

Dillon (1990: 5) says it is the interior dimension which groans and aches to be healed. "A child dies and the parents are never the same" (Dillon 1990: 5). White (1995: 69) says it is insufficiently realised that every woman who has an abortion is the mother of a dead child (1995: 69).

Dillon (1990: 6-7) says the frequent cry of "parents of aborted children" is that they never knew they would feel as badly as they do. At the time, few women ever think or allow themselves to think of the consequences. There is a sense of loss over a child never to be known. Dillon describes an ache that does not go away. "The ache of the heart takes time to heal, and it will be healed only when it is attended to and worked through despite the difficulty of confronting it" (Dillon 1990: 6-7).

In South Africa, a theologian from the University of the Witwatersrand and Anglican priest, the Reverend Paul Germond, has said that it is almost the "ultimate blasphemy" to call women who have chosen the "painful, wretched path of illegal abortion 'murderers' and make them doubt that God loves them". His understanding is to deal compassionately with a crisis and to embrace healing rather than guilt (The Sowetan 10 October 1996: 11).

A 1995 Anglican Church discussion paper on abortion states that few moral decisions are absolute (The Sowetan 10 October 1996: 11).

> Most have to be made in a context of conflicting demands...often in an agonising and pressing moment...The question then becomes: 'Under what situation may the perceived good of the mother be given greater weight than the perceived good of the foetus, and who will make the decision'? This is the crux of the issue from the Anglican perspective - we accept the possibility of abortion as the lesser of two evils under certain circumstances" (The Sowetan 10 October 1996: 11).

Jacobson (in le Roux 1994: 32) says Islamic Law allows abortion through the fourth month, although few fundamentalist Muslim countries grant this right. Hoosen (in le Roux 1994: 32) says permission is only granted on exceptional medical grounds and even family planning is not sanctioned by Islam.

Having provided a preliminary overview of the subject, the next section will move on to cover the questions that were asked of the respondents; the reasons for them; and what the literature has to say on these themes. It is important to note that there will be some overlap.

2.2.2 How long ago did you have the abortion and how old were you at the time?

This question was asked because it can provide an indication of women's coping mechanisms over time and indicate whether their reactions were delayed or not. The information can also provide insight into the effectiveness of coping strategies of the different age groups.

Although the reaction to abortion is individualistic, there are categories of women who react more adversely than others.

Adler et al. (1992: 1200-1201) say that the following factors are associated with a negative response:

- demographic factors - younger women with no children;

- length of gestation and medical procedure - those who have second trimester abortions are more likely to have negative responses than those who have terminations in the first 12 weeks; Neustatter (1986: 71) notes that research suggests that a delay in waiting for abortion adds considerably to the trauma.

- the decision process - women who report little difficulty in making the decision show more positive responses afterwards;

- perceived social support, attributions for pregnancy and coping expectancies (Adler et al. 1992: 1200-1201).

The authors say the circumstances surrounding abortion are also likely to influence later responses. These include the woman's feelings about the morality of abortion; support for abortion by the partner and others who are close to the woman; and the actual experience she has in obtaining the abortion (1992: 1197).

It is important to note that the assumptions cited in the previous study (Adler et al. 1992: 1202) that severe negative reactions are infrequent is based on the study of legal, non-restrictive abortions. The reports of Davies (1991), Neustatter (1986) and Winn (1988) are also based on interviews with women who have had legal abortions but these indicate, in many cases, greater coping difficulties. The problem is with the word severe and how to define it in human terms.

Casey (1995: 74) and Neustatter (1986: 94) list further risk factors for post-abortion complications namely coerced abortion; youth; having previous children; abortion for eugenic reasons; poor relationship with mother or partner; ambivalence about the procedure; past psychiatric history; coming from a culture or sub-culture hostile to abortion and poor coping skills.
The youth risk is supported by Dillon (1990: 31-32) who says professionals propose that experiencing the "trauma of abortion" as an adolescent and being unable emotionally to resolve the death of a child could stunt emotional growth.

Major, Mueller & Hildebrandt (1985: 585) found attributions for pregnancy, expectations for coping, the meaningfulness of the pregnancy, and whether it was intended or not, affected coping. Those who did not cope well were women who blamed their pregnancy on their character but self-behaviour blame was unrelated to coping; women who found the pregnancy meaningful; and women who were accompanied by their partner to the clinic. Women who expected to cope well, did so.

It is also worth noting that in 1989 C Everett Koop, the surgeon general of the United States in an open letter to the President concerning after effects of abortion, cautioned about the difficulty of doing solid studies on women who had abortions because denial operates as a coping mechanism in so many. He said 50 per cent of women who have had abortions deny having had one when questioned (in Dillon 1990: 9). Denial was also cited as a coping mechanism by Rue (1995: 22).

Koop (in Sutton 1995: 59) also said, after having studied over 250 articles on abortion risk, that short term studies could be highly misleading. Several authors (Blacker 1995: 48, 59; Levin 1997: 9; Neustatter 1986: 108; Sutton 1995: 59; Winn 1988: 7, 99) cite common examples of reaction being delayed until 20 years later or even on the deathbed. The late reporting raises the question whether subsequent events have been instrumental in shaping or creating the feelings for the first time or, as some counsellors report, the feelings have become an increasing burden to bear (Winn 1988: 99).

Adrian Mole author Sue Townsend said it took 10 years for the full impact of her actions (in having two abortions) to hit her and another 10 before she wrote a book about it. Her book, Ghost children, highlights the fact that taking a life, even of only a few weeks gestation, can linger in the subconscious. She said she thought she had forgotten about it but a TV documentary on stillborn children showed how the parents were not allowed to grieve "and it all came back to me in a huge rush". She began to wonder what sex her babies had been and what kind of person each of them might have turned into. She began to think of them daily (Daily Mail 30 September 1997: 9).

Davies (1991: 16) says unexpressed feelings and questions will remain an undercurrent of everyday life until they are understood and resolved. She has met women who, after decades, have not been able to integrate the experience because of the taboo and stigma and so denied their own needs.

Winn (1988: 7) says these may resurface in unexpected forms not apparently connected with the abortion. Dillon (1990: 13, 43) also states that more and more therapists are encountering patients who initially come to them for problems which are supposedly not abortion-related and as therapy continues it comes evident that the root cause of a present difficulty is a long-term reaction to a previous abortion. Kent (in Dillon 1990: 43) found the absence of negative effect cited by studies as evidence of little effect of abortion, on closer examination indicated emotional numbness, a significant negative effect in itself. Saltenberger (in Dillon 1990: 13) says it is only in recognising their repressed grief and guilt that many women are able to make progress in their emotional life but Kent (in Dillon 1990: 43) says the hurt is so deep and repressed that it will rarely be revealed outside a deep trust relationship. This is why I believe that in any type of counselling, when taking a detailed history, asking questions about past pregnancies and abortions is essential because it not only gives permission for the women to discuss it, it also to a certain extent normalises abortion as one of the experiences many women go through. This may be problematic, however if the counsellor is opposed to abortion. It is up to the counsellor to decide when it is appropriate to ask the question because there needs to be a certain level of trust for women to disclose this.

2.2.3 The nature of your relationship at the time.

The answer to this question can have a variety of implications for the woman's coping but it also provides information about what happens, depending on individual circumstances, to relationships after an abortion.

Davies (1991: 188) says abortion will affect each relationship differently according to many things, her partner's response and behaviour towards the pregnancy, each person's views on abortion, personal circumstance and so on. Many relationships break down afterwards because of a lack of understanding or desire to understand (Davies 1991: 50).

One of the themes running through Neustatter's work (1986: 25) is the lack of support given by partners and although some men are supportive, many are not. Haslam (1996: 52-53) says in his experience most men do not get involved in making the decision. This view is shared by other writers (Davies 1991: 50) who describe a range of reactions from issuing ultimatums to provid-

ing financial support and little else, to disappearing. Dillon (1990: 30) says many men were not part of the decision and feel powerless, guilty and angry.

2.2.4 Your feelings and those of your partner when the pregnancy was discovered.

This question mainly focuses on the woman's feelings and has not explored in depth men's reactions other than how it impacts on women. The effect on men is beyond the main focus of this study but it is an area that requires further research. Readers are referred to the following to read further on this. Davies (1991), Haslam (1996) and Neustatter (1986) have each devoted a chapter to the male response while Carey (1997) wrote about his own experience and Dillon (1990) refers to men throughout his text.

Haslam (1996: 17-18, 38) notes the tremendous mixed reactions of discovering an unexpected pregnancy which range from an initial overwhelming numbness, disbelief, shock and unreality to feelings of pleasure at being fertile (Davies 1991: 22, 26; Winn 1988: 12). Various authors (Davies 1991: 32; Haslam 1996: 39; Neustatter 1986: 16; Winn 1988: 11) say feelings include any of the following: anger guilt, happiness, fear, surprise, panic, disbelief, confusion, unexpected calmness, excitement, puzzlement. The Lane Commission (in Neustatter 1986: 16), when it surveyed the workings of the British Abortion Act, found that the vast majority of women felt horror, shock and fear.

2.2.5 Making the decision.

This question gives some indication of a woman's state of mind and the difficulties associated with making the decision which will be outlined in the literature reviewed below.

Haslam (1996: 7) notes that no-one ever plans to have a termination. It is an agonising decision (Davies 1991: 44-45; Winn 1988: 43). Haslam (1996: 7) says he has only met one woman for whom it seemed to be easy but it was a woman whose emotional inadequacies were the cause of many other problems.

Doherty (1995: 9) says clinical experience demonstrates that the decision to abort is "seldom fully informed" and is made when the mother is probably "heavily disturbed". Doherty (1995: 9) says it is difficult to conceive that a balanced decision could be made in a matter of weeks. Two authors (Doherty 1995: 9; Haslam 1996: 40) refer to the dilemma of the need for a quick decision. Nathanson (1990: 5) says the choice, in the end, comes from a not always fully conscious weighing of the woman's needs, and others involved.

Haslam (1996: 130-133) notes that the deciding and waiting period is difficult because there is anxiety about the length of the waiting period (the foetus is growing); what will happen in hospital; concerns about hospital treatment - whether staff will be kind; and what tests will be carried out. He says the time needs to be used constructively to work out why a termination is being sought so that when the woman is seen she can explain her views clearly and calmly. The Reproductive Rights Alliance says the average period between request and termination is about one week (Daily Dispatch 24 October 1997: 12). The wait at the Soweto clinic is about two weeks (Mail & Guardian 14-20 November 1997: 6). This may vary from clinic to clinic and counsellors will need to have this information available.

It is also important to note the urgency of making a decision. A counsellor said no-one is ever pushed to decide but it is essential to point out that the risks and the ordeal increase if the abortion is left until after three months (Neustatter 1986: 54) so the sooner the better not only in physical and medical, but also psychological and social terms (Haslam 1996: 109).

Davies (1991: 49-68) provides useful techniques and exercises on how to make up your mind and the Cincinnati Women's Service (www.gynpages.com/cws/1.html and 2.html) also provide examples of techniques such as the use of imagery. They also use a workbook entitled the Abortion resolution workbook: ways to connect the head and the heart, which they give to women to work through. This comprises lists of questions they will need to go through.

2.2.6 Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?

This question was asked because research has highlighted that this information makes a difference to coping. It was also asked so that women themselves could identify what was important for them as individuals.

For many women, the experience of abortion is made more traumatic because they have no idea what to expect (Davies 1991: 72; Neustatter 1986: 53), and although some women do not want to know (Haslam 1996: 107), others feel this would be helpful (Neustatter 1986: 77). Research has also found that many women do not feel they have been adequately informed (Allen in Neustatter 1986: 77). There is also a great deal of misinformation and myth surrounding the safety of abortion which can make the experience terrifying (Haslam 1996: 107) so to have the procedure explained serves to remove the fears surrounding the myths. Davies (1991: 72) says research has shown that women heal, physically and mentally, much faster, and come to terms with their abortions, if they know what they are about to go through.

Neustatter (1986: 77) says those who deal with patients stress the importance of giving women appropriate information when they face an abortion but this does not mean telling all. The counsellor therefore has to be sensitive to what the woman's needs are. This is how a counsellor put it:

> ...a woman should feel she knows what to expect...but...some women want and can cope with more detailed information than others...If a girl is going in for a late abortion which involves actually delivering the foetus, I think it is important she knows what to expect (in Neustatter 1986: 77).

Haslam (1996: 107) says the method used to terminate a pregnancy depends largely on how far it has developed. A lengthy explanation of the procedures and how abortion drugs work (Haslam 1996) can be found in Appendix One and while much of the detail may be unneccesary for the client, it is important that counsellors are aware of the information should they be asked. Procedures may vary from area to area and so counsellors should make sure they have the correct information.

The researcher has attempted to give as full a description as possible regarding South African methods but because the procedure is so new here and fraught with problems in terms of service delivery, this may vary from one area to another. Davies (1991: 75-85) also deals with the procedures at length.

The South African National Council for Child and Family Welfare (SANCCFW) (1997: 3) note that in South Africa in most cases local anaesthetic or analgesics are used and the patient remains awake throughout the procedure.

The following is basic information on the procedure:

- Under 12 weeks, termination of pregnancy (TOP) is a short, safe, outpatient procedure performed with analgesia and local anaesthesia if needed. Tablets of Misoprostol may be given vaginally or orally to soften the cervix and initiate bleeding prior to performing the TOP using manual vacuum aspiration (MVA). See Appendix One for full description of this procedure.)

- Between 13 and 20 weeks, the TOP is an in-patient procedure which may be performed under either local or general anaesthesia. Tablets of Misoprostol may be given vaginally or orally resulting in the expulsion of the foetus and the procedure will be completed using manual vacuum aspiration (MVA) (Halkett 1997; SANCCFW 1997: page not numbered). This is a more traumatic procedure because it involves the woman going through labour to expel the foetus.

Using a TOP referral form if available, the woman must be sent to the nearest referral hospital. Some facilities request that clinics phone in and book appointments for TOP so it is important the counsellor knows the requirements of the local facility. It is also important to know where to refer a client to for the procedure to be performed privately (SANCCFW 1997: page not numbered).

2.2.7 The abortion itself.

This section looks at women's actual experience of the procedure and their memories of it. While some are treated kindly, others are treated in an offhand manner or disapprovingly (Haslam 1996: 146: Winn 1988: 57-74) and these factors contribute to their coping with and perception of the termination (Clark et al. in Neustatter 1986: 94-95; Winn 1988: 57-74).

One woman summed up the feelings of many when she said: "It would have helped so much if someone had just thought to put an arm round me" (case history in Winn 1988: 69).

Haslam (1996: 146) says unfortunately women having terminations are frequently emotionally very brittle and assume that such off-handedness is directed specifically at them. I believe this comment is naive and in fact it often is the case that women are "punished" in this way by the medical establishment for choosing abortion. A theme in Neustatter's book (1986: 34, 49, 51) is the judgemental attitude of doctors who increase the trauma of women by their comments. She cites numerous case histories of women being told they were killing their babies, and of being subjected to rough examinations and so on (1988: 34, 62, 65) Winn (1988: 50) also attests to this attitude. The implications of this are elaborated on below.

A group of researchers at the Department of Psychological Medicine at University College Hospital in London (Clark et al. in Neustatter 1986: 94-95) found that psychiatric damage can nearly always be avoided by psychiatric support during the woman's stay in hospital and found that the attitude of those around her was extremely important, and if adverse, can outweigh the psychiatric help provided. The patient's temporary guilt and depression may be deepened by criticism, spoken or implied, by staff.

In South Africa, because the Act has only recently come into effect, some facilities do not have the correct equipment or medication (Mail and Guardian 7-13 February 1997: page unknown) and the implementation has been hampered by the fact that an estimated 50 per cent of health workers around the country do not wish to participate in abortions (Mail and Guardian 7-13 February 1997: page unknown). There also seems to be confusion in various hospitals about where the procedure is being offered such as which department to go to (Mail and Guardian 7-13 February 1997; page unknown). It can only be hoped that these problems and difficulties will be

sorted out as the implications for the care and future well-being of women seeking abortions will be compromised by the additional stress of this uncertainty.

Haslam (1996: 162) provides a great deal of information on self-care and possible problems to look out for after the operation and these are covered in depth in Appendix One.

2.2.8 Your feelings afterwards, immediately, several years later, after having children.

a. Overview

The circumstances of each abortion are unique to the individual but many of the feelings, especially of loss, grief, anger and regret are common. All too often, however, because abortion is seen as a choice, pain and sad feelings are considered inappropriate (Winn 1988: 103). This section covers some of the possible reactions and builds on Section 2.2.1.

Haslam (1996: 7) says all his patients have found that they experienced a "remarkable mixture of emotions that usually came upon them as a complete surprise". Many women had said to him "If only someone had warned me that I might feel this way", or "I simply didn't realise I would feel like this"' (Haslam 1996: 8). Nathanson (1990: 5) says she did not anticipate "how profoundly I would suffer emotionally" or how long.

Haslam (1996: 153) says after an initial feeling of relief, many women feel more tearful as the day goes on. This partly seems to happen after general anaesthetics and partly it is an expression of the loss that has occurred.

> "One moment I was fine, relieved that it was all done and dusted, and then the next I'd be sobbing my eyes out...wishing that none of this had ever happened. I don't think I was in control of my feelings at all" (case history cited in Haslam 1996: 153).

A woman cited in Haslam (1996: 83) expressed regret:

> I wish I had never had the abortion...I know that it was the right thing to do logically...But there's hardly a day ever goes by when I don't think about those twins (1996: 83).

b. Post-abortion syndrome (PAS)

The question of PAS is a controversial one because some argue it does not exist. Some of the issues raised by Dillon below as symptoms of PAS have been described by others but not as evidence of PAS or labelled as PAS. Rue (1995: 15-28) and others (Angelo; DeVeber & Azenstat;

Fisch & Tadmore; Speckhard: Standford-Rue in Rue 1995: 24) have written of PAS as a variant of post-traumatic stress disorder (PTSD) and Rue (1995: 26) says research confirms that the clinical profile is best described as a type of PTSD. Anderson, Hanely, Larson & Sider (1995: 113) note that there is no evidence on how frequently PTSD might be observed. Other writers (Blacker 1995: 47; Gindro 1995: 29; Sutton 1995: 61) have also referred to PAS. Sutton (1995: 61) says PAS may be difficult to identify. One reason is that abortion is a socially unrecognised loss. The woman is supposed to experience relief - not grief. Doka (in Rue 1995: 17) refers to "disenfranchised grief" because it is not openly acknowledged or socially supported.

Speckhard and Rue (in Sutton 1995: 62) say the onset of delayed symptoms tends to be triggered by the birth or loss of another child or some other event associated with children or reproduction. White (1995: 68) agrees and said she had often heard it said "only when I had my gorgeous baby did I realise what I did when I had my termination". This is supported by a study by Robson (in Lodl et al. 1985: 124) and Kumar & Robson (in Blacker 1995: 48).

The list below is useful because it is extensive and therefore offers insight to the helping professional whether one refers to PAS or not. It is presented here because many of these "symptoms" will be touched on in other areas of this review. Respondents also experienced many of these "symptoms" to a greater or lesser degree.

The symptoms described by Dillon (1990: 20-25) are:

- low self-esteem;
- guilt, chronic or acute; feelings of not living up to one's own standards, of betraying one's values and conscience;
- depression, chronic or acute;
- suicidal thoughts; feeling unworthy to live after taking the life of one's child;
- broken relationships: a tendency to distance oneself from those who were involved or associated with a previous abortion;
- nightmares or sleep anxiety; dreams symbolising unresolved abortion issues; women often hear babies crying in their dreams but cannot find them; dreams can also affect people who work in hospitals and clinics where abortions are carried out and who work with patients;
- flashbacks; trigger events such as giving birth to subsequent children, hearing a vacuum cleaner, seeing a picture of the hospital where it was performed, looking at a child that would be the same age;

- anger; unresolved bitterness at those involved such as the other parent, clinic staff, friends or those who suggested the abortion, and God;

- drug use, alcohol abuse, sexual promiscuity to escape the unexpressed emotional pain; to anaesthetize themselves or punish themselves.

Others include: sexual dysfunction; phobias and compulsive disorders (one woman burnt the clothes she wore to the clinic and washed continually as she felt dirty); fear of other children; inability to attend baptisms or baby showers; finding no joy in another's pregnancy; inability to relate to the opposite sex; fixating on another child; abuse of other children; atonement baby; atonement marriage (the underlying motivation to be married is to validate an abortion experience especially if the abortion was procured for the sake of the relationship). Dillon (1990: 31) says the majority of evidence indicates that abortions performed for the sake of saving or sustaining a relationship rarely succeed; struggling with what it means to be a parent; anniversary reactions; survivor guilt (Dillon 1990: 26-29). Neustatter (1986: 97) also refers to anniversary reactions.

2.2.9 Did you have any type of counselling before or afterwards?

a. Overview

Counselling has been found, in many cases, to be inadequate, but research has proven that it is beneficial. In addition there is non-positivist literature which supports this (Neustatter 1986: 40). This question was asked in order to gauge the effect, or lack thereof, of counselling.

Whittington (in Davies 1991: 100-101) has said that abortion without counselling, both before and after the operative procedure, is in his judgement, unethical and would someday, he hoped, be considered malpractice.

The Anglican Synod of South African Bishops has called on the government to make widespread skilled counselling available to women who, they believe, make the decision in dire distress (Daily Dispatch 15 March 1997: page unknown). The church offers its own resources for this purpose, especially in the case of minors and believes, as do I, that counselling should be mandatory for them (Citizen 6 March 1997: 8). Literature supporting the risk to youth is cited under Section 2.2.2 above.

I am concerned about the new South African Act because the State will only "promote the provision of" non-mandatory and non-directive counselling (The Choice of Termination of Pregnancy Act 92/96: Sec 4). In effect this means virtually nothing if viewed in the context of over-

stretched health budgets and Health Department overspending (Daily Dispatch 27 March 1997: page unknown). There simply is no money available. It will thus be left up to private welfare organisations, non-governmental organisations and womens' groups to provide counselling. Indicative of the seriousness of the lack of services is a report from the Soweto clinic where, as a result of space problems and staff shortages, all the women awaiting abortions are counselled together (Mail & Guardian 14-20 November 1997: 6).

Furthermore, the views of the Abortion Rights Action Group, may be outdated (or strategic in the context of the opposition to abortions) in that they still appear to be fighting for the right of abortion as opposed to the new focus internationally on the need for services. National President, Marj Dyer, says research shows 80 per cent of women seeking abortions have made up their minds and if they want counselling they would ask for it (Weekend Post 23 August 1997: 3). I would question the methodological validity of this research but concede there is need for research into women seeking abortions because of poverty. It may be that the struggle for survival acts as a variable which reduces the difficulties of the decision-making process as well as the effects of abortion. Staff at Baragwanath say that women seeking abortions there are adamant that it is what they want (Halkett 1997).

Counselling falls into two categories namely pre-abortion and post-abortion counselling and the requirements for both are obviously different. This section will look at the issue in general. Under the question, what would have helped, pre- and post-abortion counselling will be further examined.

A committee researching the first major United Kingdom report into the Abortion Act (Lane Commission) emphasised the importance of non-directional and non-judgemental counselling in a circular to all authorities in 1977 (in Haslam 1996: 58-59). Other writers (Davies 1991: 89; Winn 1988: 52) agree about the need not to assume or impose one's own solutions when women seek help but I believe this is the ideal and not the reality. The committee said:

> Counselling should aim to ensure that the pregnant woman has a full opportunity to make a reasoned assessment of her own wishes and circumstances, to obtain any advice she may need in reaching her own decision and to see that any aftercare facilities including social work help which she may need can be made available. In helping the woman to understand the implications of termination or the continuation of pregnancy, it is essential that counselling should be both non-judgemental and non-directional. It is in no sense a way of putting pressure on the woman either for or against abortion (Department of Health and Social Security health circular in Haslam 1996: 58-59).

The whole issue of counselling, however, the format it should take and the reality of what happens, is complex and fraught with problems. There is sufficient evidence in the literature that counselling is helpful and plays a supportive role in helping women make a difficult decision (Neustatter 1986: 94). On the other hand, because of the need for approval from two doctors for the abortion, women often have a long lists of reasons (Davies 1991: 89) which may not necessarily have been thought through. Some women also resent having to discuss it further when they have made up their minds.

Several writers cite case histories, abortion counsellors and research that supports this view (Ashton in Neustatter 1986: 94; Neustatter 1986: 90; Winn 1988: 41). Furthermore, counsellors (cited in Winn 1988: 47, 106) agreed that it could be destructive for a woman to go through the ordeal without exploring her feelings and it could mean she did not face up to what she was doing until afterwards. Another counsellor notes that it can never be made a pleasant experience, but counselling can prevent it from being a traumatic one (Neustatter 1986: 54). Research also indicates that the development of severe guilt depends not only on the constitution of the woman but on the prevailing social attitudes to her action in undergoing an abortion (Ashton in Neustatter 1986: 94).

b. Role of the counsellor

It is clear from the above that the role of the counsellor would be to help the woman sort out her conflicting feelings and emotions and provide a supportive environment in which to explore her options calmly, rationally and methodically.

Haslam (1996: 59-60) notes that counselling can achieve more than simply being a guide through decision-making, good counselling can help a woman reach a better understanding both of herself and her behaviour and the circumstances that led to her problem. She may understand her sexuality better and sometimes may learn how to take better control of many aspects of her life. He says many women see it as a hurdle that has to be crossed to earn a termination but it should not be so.

c. Who should counsel

I agree with Davies (1991: 101) who notes that informal counselling is practiced by friends and partners but although this can be effective, sometimes people are too close to the situation and cannot resist giving advice and trying to solve the problem.

(i) Doctors and other health care providers

Haslam (1996: 56-57) says a good general practitioner should be able to offer counselling but the woman may also have a very dogmatic doctor who tries to tell her what to do. The problem of judgemental doctors and the implications thereof has been addressed under Section 2.2.7 above. In my opinion doctors are far too busy to offer the type of counselling needed and at best this would be superficial although they could provide information regarding how the procedure is carried out and allay fears regarding the risks involved in the operation and to future pregnancies.

In South Africa if a doctor is opposed to abortion he is duty bound to refer the woman as the Act states that "any person who prevents the lawful termination of a pregnancy or obstructs access to a facility... shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years (The Choice on Termination of Pregnancy Act 92/96: Sec 10).

The SANCCFW (1997: 1-2), which has provided an information package to their societies around the country on abortion counselling, believe counselling is primarily a health responsibility and that specific hospitals designated to perform terminations will eventually have appropriate staff to undertake counselling. Their societies will agree to counsel on the social issues and options open to a client. The SANCCFW says termination of pregnancy (TOP) counselling should cover legal, social and psycho-sexual issues. If staff do not want to provide counselling they have the professional responsibility to refer, the cardinal principle being that the wellbeing of the client comes first (SANCCFW 1997: 1-2).

The SANCCFW (1997: 2) note that the Department of Health are using existing resources for training in abortion counselling and they were advised that provincial health authorities will assist with training if required. Eventually the nursing curriculum will include abortion counselling (SANCCFW 1997: 2).

(ii) Social workers and other mental health care providers

Social workers have the training and the skills to offer the type of non-directive and non-judgemental counselling that is required. However, the social worker or any other helping professional contemplating, especially pre-abortion counselling, must be sure of his or her own feelings on the subject: she must firmly believe in a woman's right to choose. It is not acceptable in this very sensitive area of counselling to say, as the researcher heard a student social worker say: "I would state first that I am opposed to abortion and then try to help her" because the woman would feel judged. I believe that abortion counselling is a specialised area and not all social workers are suited to providing this particular service.

Allen (in Neustatter 1986: 510) established that women who talked to abortion counsellors found this more helpful than talking to doctors, consultants or social workers and this supports my view that it is a specialised area of service delivery.

The SANCCFW (1997: 4) propose an alternative trained human resource category namely lay counsellors from local communities, provided with the relevant in-service training and support, to meet the unique South African circumstances of the poor in rural areas. The body notes that abortion counselling can be emotionally draining so caseloads would need not to be too high and workers should be part of a team in order to obtain mutual co-operation and support. For lay counselling to be cost effective the SANCCFW says there should be a general lay counselling training to which can be added a variety of speciality areas such as youth work, marriage guidance, abortion and so on and allow the counsellor to add courses as required. The body says abortion counselling should not be made unrealistically exclusive and lay counsellors with the right personal outlook and attributes, who are intelligent and willing to learn, can be trained to undertake the work (SANCCFW 1997: 4).

In England private organisations such as the Post-Abortion Counselling Service (PACS) in London offer a free 24-hour answering service. The organisation comprises professionally trained women who are committed to providing counselling help to as many women as possible (Haslam 1996: 249).

d. How much counselling is needed pre- and post-abortion?

The answer to these questions obviously depends on the individual but it is useful to look at what some of the writers already referred to have to say. Winn (1988: 43-44, 46) notes that often there was not enough counselling (in National Health Service hospitals, often nothing, while at clinics, 15 minutes) and that most women spoken to expressed a need for more or better counselling right at the start as an aid to decision making (Winn 1988: 50).

Some private abortion clinics in Britain allow for an appointment up to 45 minutes and allow the woman to return as often as she wants after that before making a decision (Neustatter 1986: 54).

In South Africa the situation varies from service to service. Marie Stopes International offer a pre-abortion counselling session where options are provided, a post-abortion counselling session and a follow-up to discuss contraception, and state hospitals are said to offer both pre- and post-abortion counselling (Weekend Post 23 August 1997: 3) but the efficacy of this has yet to be determined. A spokesman for Marie Stopes in England says they make pre-abortion counselling available, but fewer than half request it and they believe that most clients have already

discussed their decision with partners, parents or friends and that compulsory counselling was not to their advantage (Haslam 1996: 101). That is not to say that this is so for many women but in view of the evidence to the contrary in the literature cited elsewhere in this review there are many others who do need counselling.

I believe a minimum of a 30 minute interview should be held to assess the woman's decision and to screen for the risk factors which may affect her coping (described under Section 2.2.2). This should not be in the context of trying to convince the doctor that she needs it but by a professional to assess whether she has fully explored all her options. In view of the evidence that a thoroughly thought through decision with the assistance of counselling is beneficial, this is a suitable compromise.

It is also necessary to caution that in Britain it has been found that few women keep follow-up appointments at private abortion charities and the general view is that women do not feel comfortable about returning to the place where the abortion was set up (Neustatter 1986: 106). This indicates that post-abortion counselling services need to be provided at a different venue.

2.2.10 What was useful, what was not?

This question was asked with a view to women themselves identifying what was useful in counselling and what was not.

a. Reasons for pregnancy

Several authors (Davies 1991: 22-24, Neustatter 1986: 53; Winn 1988: 11) say there are many and sometimes sub-conscious reasons why women fall pregnant unexpectedly. Davies (1991: 24) says part of the "standard post-abortion chat" concerns future contraception, indicating that, it is assumed failure or lack of contraception is the major cause. It often is not and it is therefore necessary to consider the reasons as this will form an essential part of counselling to prevent future unexpected pregnancies and so the woman can obtain some insight into what has happened to her.

b. Contraception facts

The timing of the provision of contraceptive information must be handled with sensitivity. Haslam (1996: 23) quotes a patient who was angry at doctors who treated her as if she was irresponsible

with contraception when she had been careful. It made her furious "I had enough on my plate without being told I was incompetent too".

Paintin (in Haslam 1996: 22) found in one study that of women requesting termination, 42 per cent stated their partner used a condom, 22 per cent were on the pill, but 28 per cent - over one in four - admitted to using no contraception at all. Haslam says the area of risk of failure to use contraception could be reduced by good sex education but says passion has been passion since the beginning of time and inevitably not every act of intercourse will be planned in advance. A clinic in Soweto which is performing abortions has found that the overwhelming majority of women using the service have not used any contraception and that few are aware of emergency contraception (Mail & Guardian 14-20 November 1997: 6).

It is beyond the scope of this study to go into detailed descriptions of the contraceptive methods available as it is obtainable elsewhere. It is also essentially medical or family planning information but I believe counsellors should keep themselves informed with up to the minute information.

c. Emergency contraception

Haslam (1996: 27) says sadly very many women are either unaware of emergency contraception - namely the intra-uterine device (IUD) and morning after pill - or do not think of it in time. In a survey in 1995 the British Family Planning Association found that whilst some 97 per cent of women had heard of emergency contraception, three quarters had no idea about the time limits in which it could be used and fewer than one in 10 knew of both methods (Hall in Haslam 1996: 30).

(i) Morning after pill

Haslam (1996: 26) says the name morning after pill should be abandoned because this form of oral contraception is effective for up to 72 hours after intercourse. He says using a term such as three days after pill might not be a catchy name but if more couples realised that this was the time limit, then a large number of abortions could well be avoided. Information about how it works, its efficacy and so on is available on the Internet (www.gynpages.com/cws/3.html).

(ii) IUD

Alternatively an intra-uterine contraceptive device can be inserted effectively up to five days after unprotected sex (Haslam 1996: 26).

2.2.11 What would have helped?

As with the previous question this one was asked in an attempt to obtain the respondents opinions. This section will provide an overview of what has been identified as the best possible process of counselling from before the abortion to after and women's experiences. It will be divided into pre- and post-abortion counselling. Miller (1992: 91) says the predictors of post-abortion trauma highlighted under Section 2.2.2 above have important policy implications namely that it appears possible through both pre- and post-abortion counselling programmes to reduce the prevalence of post-abortion distress. This, however, does not account for the feelings of loss that accompany an abortion.

A woman may come into contact with a counsellor at any stage of the process from the first discovery of the pregnancy to years after a termination so the intervention strategy is informed by the stage she is at.

a. Pre-abortion counselling

Firstly, the counsellor would need to ascertain whether or not the pregnancy had been confirmed and how far it had progressed (Haslam 1996: 49) and refer the client to sources where a test would be available depending on her financial standing. These would include her doctor; a home test obtainable at a pharmacy; some family planning clinics and private abortion clinics such as Marie Stopes International which has seven branches in the major centres in South Africa (Week-end Post 23 August 1997: 3).

• Exploring the options

Several case histories illustrate how objective counselling, which provides for a consideration of all options (Davies 1991: 33; Haslam 1996: 45), assists decision-making and clarification of issues (Davies 1991: 92; Haslam 1996: 60). The woman should look at each option first practically and then whether she could handle it emotionally (Davies 1991: 31).

(i) Keeping the baby

Things to consider regarding keeping the baby and remaining a couple are the financial implications: could you cope; could one of you give up work; who would it be; and would it mean getting married (Davies 1991: 35).

Going it alone as a single parent involves needing a support system and similar questions need to be asked about financial coping and practical questions about where to live; what about your

job; who will support you; will the father help at all; have you considered what it will be like in a year, two or five years on; who will help in later stages of pregnancy with practical arrangements; what about future relationships: how will a baby affect them; can you take the place of two parents; are you emotionally strong enough; what would you give up; do you qualify for any state benefits (Davies 1991: 35). While Davies highlights the social security benefits available in England, in South Africa and other developing countries these are severely limited but a counsellor needs to be informed so she can give accurate information.

(ii) Adoption

In South Africa adoption is not always a solution. The assistant director of Johannesburg Child Welfare, Celia Theart, says white couples wait for months for white babies, but there are many black babies waiting for prospective parents (Daily Dispatch 22 August 1995: 12).

Davies notes that this route may bring its own problems such as difficulty in keeping to the decision and changing your mind several times as well as stress at work caused by colleagues who do not understand your circumstances: they will assume you are keeping the baby (1991: 37).

The social worker should explain fully the adoption procedure. Questions to ask are: can you face going through the physical process of pregnancy; how will you feel when the baby is born; what does your partner think; is this your decision; would you want to see your baby afterwards; could you cope with knowing you have a baby somewhere; could you cope financially at this time; what about work (Davies 1991: 37).

Haslam (1996: 44) notes that carrying a baby for nine months and then handing the infant over to somebody else can be very traumatic, although it is possible to change your mind and in terms of the new child care legislation in South Africa which is due to be implemented, a mother will be able to change her mind up to 60 days after handing her baby over (Information session on new and current child care legislation : 2-3 September 1997).

(iii) Abortion

This choice also needs to be fully explored with the woman. Is it what she wants; is her partner putting pressure on her; or can she just see no other way out? Haslam (1996: 50) says the decision will come from considering all the different angles: practicalities, her feelings about termination, religious views, medical and physical problems, the psychological impact and the

support she might get. It is also important to persuade women of the importance of medical follow-up after abortion (SANCCFW 1997: 3).

• Challenging, sensitive and thorough

I believe that counselling should be non-directive but it should also be challenging and whether it is the right decision for the individual woman should be thoroughly explored.

Winn (1988: 48) uses a case history to illustrate this point:

> It was all too easy. I felt I wanted someone to make it difficult for me. The counsellor accepted all my reasons...I thought she would get me to question my motives, to look at the positives. I was 22. I had a career, I had a boyfriend. A baby was possible (Winn 1988: 48).

Neustatter (1986: 42-43) and Winn (1988: 55-56) provide similar examples and Winn (1988: 50) quotes an example where a woman felt the counsellor was too objective and should have told her "this matters what you decide now".

Haslam (1996: 142-143) reviews a case which had a different ending - a 27-year-old woman who kept her baby, "the best thing that ever happened" to her, after the consultant repeatedly challenged her to examine her needs. These examples point to the need for challenging but sensitive counselling to help a women past the initial shock and possible denial to realistically exploring her options (Haslam 1996: 156-157), even if only briefly.

Neustatter (1986: 52) quotes a senior counsellor who says a woman has to be helped decide whether she has a value system which will allow her to live with the knowledge afterwards. Many women present saying they have never agreed with abortion before but being pregnant they now think differently. She says these women need to be sure they really mean that and that they can make the experience part of their history.

• Being told grieving and other feelings are part of the process

A senior British abortion counsellor says she tells all clients irrespective of their circumstances that they will grieve. She says all counsellors are involved in bereavement counselling and she feels it is "extremely important" to warn a woman in advance of what she might feel later on. She says for women whose lives are busy, pragmatism takes over and they carry on and what can happen is that the shock takes place later (Neustatter 1986: 105).

Another counsellor says by telling women beforehand of these possible feelings it effectively gives them permission to have them rather than suppress them because commonly women feel that by choosing abortion they have forfeited any right to those sorts of feelings (Winn 1988: 47, 117).

Another counsellor tells women that pregnancy starts out as a pleasant experience for some while others feel invaded by a monster and by saying this she gives them room to say what they feel not what they think they ought to feel (Winn 1988: 122).

Jackson (www.gynpages.com/cws/1.html) says she has seen that using clinical language such as "fetus" when the patient is using "baby" will signal to her that her pain or grief is inappropriate, closing the door to honest communication before it is fully opened. The Cincinatti Women's Service thus listen carefully for verbal cues the patient may be unaware of as well as nonverbal ones such as saying she is comfortable with her decision but being unable to make eye contact. Haslam (1996: 153) also refers to similar possibilities for misunderstanding where a woman may feel the depth of her loss and grief can be negligently underestimated when someone regards the abortion as simply the "removal of a few cells".

The SANCCFW (1997: 1-2) note that post-abortion depression should not be an automatic cause for concern because after an abortion, as after a delivery, there are sudden changes in hormone levels and women should be warned to anticipate this as one possible reaction.

• The procedure and its safety

It is important to provide medical information about the abortion so the woman is fully prepared for what to expect, as well as clear up any myths and misconceptions about its safety (Neustatter 1986: 53) as these can heighten her anxieties and affect how quickly she recovers (Haslam 1996; 160; Winn 1988: 117). Although this service could be provided by health personnel, the reality is they are often too busy to do so.

Questions such as how will the operation be performed, what type of anaesthetic will be used, what are the risks involved, how long will I stay in hospital, will I have a follow-up appointment, will I be able to see a counsellor, what about sex and contraception, what do I need to take to hospital, and what happens if there are any complications afterwards, all need to addressed (Davies 1991: 73).

Neustatter (1986: 78) notes that information about risks is often presented in its worst light by those who disapprove of the choice. "...women...may become sterile, or may have great problems conceiving or bringing a baby to term. This is the price to be paid...and many believe it"

(South in Neustatter 1986: 78). Davies (1991: 81-85) also deals with the risks and myths surrounding abortion. A common fear is about not being able to have children. Haslam (1996: 6) quotes the following case history:

> The doctor told me that I really 'was a silly girl'...and that I would probably always find it difficult to have children in the future if I had the abortion now (case history in Haslam 1996: 184).

Haslam (1996: 15) notes that in 1986 in the United Kingdom no women died as a result of termination although 45 women died as a result of pregnancy. He says any operation carries a small risk that the patient might die. However, the risk of this occurring because of termination is tiny (about one in 100 000). In comparison, the risk of death associated with childbirth is about 10 times greater (one in 10 000) (Haslam 1996: 176-177). Davies (1991: 82) says it is 20 times safer than childbirth. Haslam (1996: 75) also notes that in the landmark United States Roe vs Wade case the judges statement took note of the fact that early induced terminations had become safer than childbirth.

Haslam (1996: 176) says overall about five per cent of women will have some form of complication. There are two major potential causes of risk to future fertility (Haslam 1996: 185). An infection could damage the Fallopian tubes and the operation itself could damage the cervix. A 1990 study confirmed the low risk but stressed that women having multiple terminations are at greater long term risk of infection (Huggins and Cullins in Haslam 1996: 185). The risks are much greater after illegal termination (Haslam 1996: 176).

For a full explanation of the problems that may arise after an abortion see Appendix One.

• Illegal abortions

Haslam (1996: 184) says complications of illegal abortions can be very serious and dangerous. In the long term infection can lead to scarring of the Fallopian tubes, which can easily lead to long-term infertility.

Neustatter (1986: 88) says it is clear that women's health and sanity is vastly more at risk when they must resort to illegal practices than when abortion is legalised.

Each year an estimated 200 000 women die as a result of illegal abortions mostly in the developing world (Daily Dispatch 25 September 1997: page unknown). The South African Women's

Health Conference in their 1994 policy document stated that 10 per cent of women who had illegal abortions died. Despite the medical side-effects of infertility, infection and anaemia, the psycho-social impact was devastating with women frequently suffering from depression and feeling powerless and alone (Women's Health Project 1995: 120).

The above makes implicit the need for post-abortion counselling services in South Africa where hundreds of thousands of women have resorted to backstreet abortions.

b. Post abortion counselling

• Overview

Haslam (1996: 232) says post-termination counselling can make a tremendous difference to women who have long-term emotional problems but I would say this applies more widely. He says many women will not have anyone to talk to and some will feel that the feelings they are experiencing are simply too deep and too distressing to share.

> After all how often does the experience of termination come up in everyday conversation? It is incredibly seldom, when you think of the enormous number of women who have had terminations (Haslam 1996: 232).

Haslam (1996: 232-233) says the woman's doctor will refer her or she can enquire at the clinic or hospital where she had the termination. Many will have their own counsellors. In South Africa, the provision of counselling services is in its infancy and initiatives are needed to ensure adequate counselling is made available.

Counselling cannot be a panacea, however, especially considering many women shrink from it preferring not to deal with the pain. Also, if the woman does confront the issue, there is still a great deal of work she, herself, has to do as the following point illustrates.

Nathanson (1990: 6-7) says the efforts of others who cared about her could not themselves restore her to a sense of wholeness and peace. The work of restoration was essentially hers; completing it successfully took years of psychological effort on her part, combined with the active support and assistance of others.

> The bigger the soul-crisis, the stronger the support that is required; my crisis required the assistance of my husband, family, and friends, a guide found in an unexpected place, every iota of knowledge gleaned from my years of work and study as a psychologist, and the help of myth and ritual (Nathanson 1990: 6-7).

Nathanson (1990: 7) says individuals who are grappling with a crisis of soul need a strong "holding environment", a container that can hold them securely until their intense emotional reactions subside and the sense of self that was shattered by the crisis can be reconstituted in a new way. She says there are three layers to this, the first being composed of the human relationships within which the person in crisis feels understood empathically, the second layer may be provided by the culture, if the culture recognises the crisis as warranting concern. She says a third layer may be provided by the archetypal or universal realm of wisdom available to each of us which surfaces in the form of myths, images and dreams and can be evoked by rituals. She says we are used to drawing on this realm for losses such as death or illness but most of us are less inclined to avail ourselves of it for help in bearing the emotional anguish that may arise from an abortion.

Neustatter (1986: 21) notes that even women who do not experience intense emotions and who feel they have made a correct and reasonable choice, are clear that it has not been a pleasant thing to do and they would not wish to have to make the choice again.

• Griefwork and mourning

Davies (1991: 128-129) notes that most of the feelings associated with abortion such as anger, guilt, sadness and numbness are symptoms of loss. Various authors (Davies 1991; Doherty 1995; Neustatter 1986) write about the grief that accompanies an abortion. The main focus of post abortion counselling therefore needs to be on grief and loss.

Davies (1991: 146-148) notes that there are many references to grief in books about pregnancy loss such as stillbirth and miscarriage but nothing about the loss that is felt as a result of abortion. She says acknowledging the feelings is the first step to coping with the loss. She says grief is not something we carry out but is something that happens to us and is a way of adapting from the old you to the new you. She says for some abortion can be both an actual and symbolic loss. It can be the loss of our childhood, the loss of trouble free relationships or the loss of a potential baby, a part of ourselves.

Davies (1991: 128-129) says avoiding grief can often last for some time and may explain why many women who experienced abortion before 1967 (when abortion was illegal in the United Kingdom) still suffer today. The secrecy and taboo which surround abortion can often force women into inappropriate coping, namely depression. However, if women can recognise this they can start grieving and counsellors can assist them to do so. The implications for South African women who have undergone illegal abortions in the past are made clear by these comments.

Davies (1991: 150-151) notes that over a long period unresolved loss can cause many emotional and physical problems, such as lack of energy, restlessness, tension, insomnia, loss of appetite and panic attacks, aches and pains irritability and frequent crying.

Davies (1991: 152) notes that in countries where abortion is not considered taboo, attitudes towards abortion and, consequently, post-abortion, feelings are different. In Japan, where abortion has been legal and accepted since 1949, couples have a ritualised mourning - a form of memorial for the baby. Couples name the baby and openly acknowledged its loss, which is widely accepted, with little trauma for those concerned, She says in this way the disastrous effects of unresolved grief are rarely encountered.

Casey (1995: 74-75) says views such as 'but you can't undo what I have done' are commonplace and it is important to emphasise that the goal of treatment is to assist the patient to live with what has happened, rather than to persuade her that it was all right or that she should forget about it. Issues such as low self-esteem, assertiveness training and problem solving techniques may be necessary.

Davies (1991: 16) says that although there is no magic cure, with self-help, knowledge and support, most women can integrate the experience into their lives and heal naturally and completely. I would suggest that completely is too strong a term because Davies herself dedicates the book to her unborn child "always in my heart". I believe acceptance is the more accurate term and goal.

Counsellors who require further information and the outline of the grief process are referred to the book On death and dying by Dr Elizabeth Kübler-Ross. Davies (1991: 147-178) and Dillon (1990: 34-59) also deal extensively with the grief and healing processes and readers are referred to these chapters for further detail. The classic stages of grief are: denial and isolation, anger, bargaining, depression, acceptance (Kübler-Ross. Davies 1989).

• Support groups

Lodl et al. (1985: 127) say the value of support groups has been cited by a number of authors as serving a number of purposes: to alleviate alienation and isolation (Brashear 1974; Freeman 1977, 1978); to (reinforce coping mechanisms (Payne et al. 1976; Urman & Meginnis 1980); and to facilitate the mourning process (Gould 1980; Horowitz 1978). Lodl et al. (1985: 127) provide a model for support groups comprising closed groups for two to eight women which meet for two hours a week for six weeks. Goals include providing information about the grieving process; understanding the various types of loss that the abortion may represent; assessing values and life goals; and experiencing support from other women by sharing differences and commonalities. For an in depth explanation of how these groups work readers are referred to Lodl et al. (1985: 127-130).

The problem with these groups is the outreach to the client population because many women keep their experiences a secret. Lodl et al. (1985: 130) say public education regarding the value of the groups is therefore an important first step to overcoming these barriers.

Winn (1988: 103) said many women feel post-abortion groups or therapy of a general kind had a very important impact on how they had made sense of their lives.

Neustatter (1986: 1) notes that after the screening of the film, Mixed feelings, which focused on the human rather than the campaigning experience of abortion, more than 1 000 women asked for information about setting up self-help groups and expressed their relief at seeing other women felt as they did.

A woman who set up a woman's post-abortion workshop in London, Mira Dana, says by breaking the secrecy and silence and by acknowledging the feelings involved, a woman can reduce the torment of having to cope with them on her own and thinking she is the only person in the world who feels this way (Neustatter 1986: 107).

Dana's workshops last a day and each woman is asked to talk about what happened to her, what her feelings were and are and how she felt she was treated. They are encouraged to be as sad or as angry as they wish and many women cry for the first time in this environment (Neustatter 1986: 107).

Groups can be one off or run over several weeks. That they are comprised of women from different backgrounds does not appear to matter (Neustatter 1986: 108-109), what draws the women together is their shared experience.

• Some useful techniques

Reference has been made in the text of specific coping strategies and readers have been referred to both Appendix One and specific works, but additional information is provided here of alternative methods to assist coping and resolution.

• Self help

Nathanson (1990: 3-4) says she first wrote to describe her experiences of the abortion because she felt she would "burst from the pressure" of the painful and conflicting feelings she carried inside her. Writing about them not only helped her place the internal turmoil outside of herself, relieving the pressure, but it also enabled her to put her inner discord to positive use by sharing her experience with others as well as understanding them and giving them meaning (1990: 3-4). Author, Sue Townsend, has exorcised the ghosts of two abortions 20 years ago, by writing a

book entitled Ghost children which was published in October 1997. She says the book is about "loss, bereavement and the repercussions of things. It has been immensely cathartic" (Daily Mail 30 September 1997: 9).

Thus a counsellor could encourage this type of outlet for women who have had abortions and who are struggling with the emotional aftermath.

Casey (1995: 80) suggests writing a letter to God or holding a commemoration ceremony for the infant. Another pointer to a possible healing act is that given by Carey (Femina 1997: 64) who wrote with regret that he and his wife had not honoured their twins with a plaque or a name. "I will always wish that. Forever." His wife lost the twins as a result of an incompetent cervix (see Appendix One) following an earlier illegal abortion.

Davies (1991) throughout her book offers useful mechanisms to deal with the situation at every stage of the process from decision making to resolution and this work is highly recommended.

- **Complementary therapy**

- Haslam (1996: 168-170) says many people find that complementary therapies can be helpful afterwards. His suggestions include:

- aromatherapy, using Rose Otto which it is claimed is capable of regulating the entire female reproductive system whilst having a nurturing effect on the emotional level;

- homeopathy, a consultation is preferable to over-the-counter remedies; and

- acupuncture.

2.2.12 Who else knew, did you talk to?

Haslam (1996: 50-51) says perhaps the single most important first step is deciding who to tell as it is not fair that the woman should have to make the decision on her own eg. partner, parents, family, doctor, friends or counsellor (Haslam 1996: 50-51). While Haslam is describing the ideal, many women do not have adequate counselling to assist them and in South Africa many have none at all, and others do not want it as they see it as an intrusion rather than a benefit (Smith 1997: 3).

Haslam (1996: 55-56) notes it is a woman's right to decide whether or not to tell her parents. One mother said she felt guilty and upset about her daughter's pain and blamed herself for not talking to her children about sex. Neustatter (1986: 45) notes that mothers, after the initial burst of anger and feelings of hurt, end up being helpful and supportive of their daughters.

Haslam (1996: 55-56) says the woman may need parental help for practical reasons such as finance or she may be living with them and find it hard to arrange a clinic admission without their finding out. Some parents are more upset that they have not been confided in than about the pregnancy and may feel deceived and this can compound the woman's feelings of guilt. If the woman fears their reaction an intermediary can be of assistance.

Haslam (1996: 6) quotes a case history where a woman said talking to someone who had been through the same experience really helped.

2.2.13 Did you have any religious or moral views on abortion before the termination or after and did these change?

This question provides an indication of what services a counsellor will need to render. Research has made some interesting discoveries in this respect.

Casey (1995: 80) says some women from religious backgrounds do not seek spiritual guidance but many who are not committed to any religious group do request help from religious sources.

Davies (1991: 151) notes that punishment is a common them among women who have had abortions. She says coping will be made more difficult if the abortion is blamed for everything that subsequently goes wrong. These include guilt feelings, long lasting anger, consciously or sub-consciously destroying relationships or flitting from one to the other, increased promiscuity, repeat pregnancy and abortion.

One woman had this to say: "I feel my punishment will be that children are forever denied me - I have forfeited the right to create" (case history in Davies 1991: 160). This view is supported by counsellors who also say that the other fear is that they will have a child who will have some impairment (Winn 1988: 53).

Women who are opposed to abortion for moral, ethical and religious reasons, and who contemplate and resort to abortion when faced with an unplanned pregnancy and other options are limited, may require the spiritual healing outlined by Dillon (1990). It is thus important that counsellors have access to a number of ministers of religion.

If the person is a Christian or other religion the counsellor will obtain useful information by asking questions such as what does God think of you; what would He say to you. Dillon (1990: 46) says this will help in gaining a clearer picture as to where a particular person is in their relationship with God and in their healing process.

Dillon (1990: 13-14) states that the church has maintained a strong stand on the sanctity of all human life from the moment of conception but says it also insists on the "immensity of God's forgiveness and mercy". Dioceses across America are establishing reconciliation and healing programmes. Project Rachel, as it is known, goes beyond the basic pro-life premise and states that the sacredness of the lives of those who aborted must also be maintained. They too are "precious and irreplaceable in the Lord's eyes" even though they might not believe it.

Dillon (1994: 14) says the path to healing can be painful and demands trust and courage. He says to face the "ugliness and truth of our mistakes" is never easy for anyone. "We cannot be healed of the things we are unwilling to face" (Mannion in Dillon 1990: 14).

In order to cope with the pain many will employ the defence mechanisms of denial, rationalisation and repression simply to survive emotionally in their day to day lives (Dillon 1990: 14).

Part of the problem according to Dillon (1990: 15) is that there is no wake at which to say goodbye to their child, no funeral at which to release their child to God, no body to remember their boy or girl by, simply a date on a calendar.

Post-abortion ministry is founded on the premise that women and men who have suffered through an abortion have a right to grieve; they have a right to acknowledge and work through their feelings of remorse and guilt. Dillon (1990: 17) outlines the process of helping - of gentle confrontation and acceptance of sin and the prayer rituals that go with it - but because this work would be outside the experience of social workers and other helping professionals, readers with interest in this aspect are referred to Dillon's book. He deals with the process of healing and reconciliation and its Biblical base in depth in chapter 3 from page 34-59.

Neustatter (1986: 113) quotes a woman who felt afterwards that she was unlovable.

> In the end I went to a priest who was very kindly and helpful and he didn't condemn me but said, 'God makes these rules so we don't hurt ourselves' - he felt I had made the wrong decision for me (Neustatter 1986: 113).

2.2.14 Did your feelings about having children change after the abortion?

This question was asked because the literature indicates some women want to rush into pregnancy again (Davies 1991: 200) while others avoid it. As can be seen from the preceding information many women also fear they will be punished and not be able to have children or that the child will be in some way damaged.

2.2.15 What would you say to someone seeking an abortion?

This question was asked because I felt it would help further identify the woman's feelings and identify what had or may have helped them as well as indicate what counselling was needed.

2.2.16 Would you have another abortion?

Some women feel vehemently that they would not but in the United Kingdom repeat abortions account for 10 per cent of all terminations (Davies 1991: 200) and of my sample, two out of five, had two abortions. Davies (1991: 200) says it cannot be seen to be easier the second time, and there is greater self-recrimination and from professionals.

> The decision to have an abortion is terrifying...I still haven't properly come to terms with it...I couldn't go through it again (case history in Neustatter 1988: 26).

> I would never have one again, whatever the circumstances...What I feel is not about killing babies, but that conception and birth are miracles and have a meaning beyond anything we necessarily know about (case history in Winn 1988: 104).

Another woman said she had two abortions but both were under different circumstances and made her react differently (case history in Davies 1991: 200).

2.3 CONCLUSION

This review has considered the current literature available on abortion but there has been an intentional focus on negative effects because the purpose of this thesis is to look at counselling needs of all women who have abortions but specifically those who battle with issues of loss with little outlet for dealing with that pain.

CHAPTER 3
METHODOLOGY AND RESEARCH DESIGN

3.1 INTRODUCTION

This chapter will examine the methodology of the study and how it was undertaken. It will also consider the limitations and validity of the findings.

3.2 DISCUSSION

3.2.1 Research design

A qualitative study was chosen as stated in Chapter One as this type of research lends itself to investigating deeper meanings of human experience (Rubin and Babbie 1989: 364).

Van Maanen (in Miles and Huberman 1996: 10) says qualitative research's emphasis on lived experience makes it fundamentally well suited for locating the meanings people place on the events, processes, and structure of their lives: their perceptions, assumptions, pre-judgements and pre-suppositions. Qualitative investigation has often been advocated as the best strategy for discovery and developing hypotheses and testing these to see if predictions hold up (Miles and Huberman 1996: 10).

3.2.2 Research methodology

I conducted five in-depth semi-structured interviews comprising open and close-ended questions along broad themes. I discovered, however, that having completed the literature review, it became necessary to ask additional questions. Issues raised by respondents also gave rise to additional queries ie. the role of dreams in coming to terms with an abortion. In this instance, when respondents were asked to check the interviews these additional questions were raised. Some interviews were also more detailed than others simply because the respondents were more comfortable telling their stories and required little prompting.

In addition, because of the nature of the topic it was sometimes difficult to develop a particular area of questioning because the respondent would continue with her story, additional information would arise and the thread would be lost. In the hands of a more experienced researcher this may not have happened but it thus became necessary to go back to the respondents to clarify certain responses. This was accomplished both by telephone and face to face.

An interview format was chosen because of the nature of the topic, its adaptability and because it allows the researcher to "follow up ideas, probe responses and investigate motives and feelings, which the questionnaire can never do. The way in which a response is made (the tone of

voice, facial expression, hesitation, and so on.) can provide information that a written response would conceal...a response in an interview can be developed and clarified" (Bell 1993: 91)

While I had planned to ask the questions stated in Chapter One, once the respondents began talking there was little need to do so as each individual simply told their story. I found it was not useful to interrupt but rather at the end asked any questions that had not been covered.

Respondents were also asked to read over their transcribed interviews to ensure accuracy of recording and to acquire any additional information or elaboration that the respondent felt was necessary. Bell (1996: 96) says transcripts and statements that will be used as direct quotations should be verified to avoid being challenged at the report stage.

The interviews lasted between 90 minutes and two hours with subsequent telephonic contact and meetings considerably shorter.

3.2.3 Ethical considerations

In keeping with University guidelines on ethical standards, at the outset respondents were told the purpose of the research and how I hoped it would generate guidelines for both pre-and post-abortion counselling. I said the goal was to create awareness of women's rights to mixed feelings and the concomitant rights to support and counselling. I explained that I would ask questions to elicit the story of their abortion and that this might bring unresolved feelings to the fore. If this happened the respondent should seek counselling from the available resources in the community such as social workers or psychologists. I could refer if required. After the interviews I contacted the women to establish that were all right. Counselling was again suggested to Kim when she said she felt "shit" afterwards. I also asked if the respondents would like access to any of the literature and this offer was accepted by Nadine. It was also explained that anonymity would be maintained through the use of pseudonyms.

Miles and Huberman (1996: 290-297) refer to numerous ethical questions in analysis such as the worthiness of the project, for which in this instance, a motivational case has already been given. There is also the issue of competence boundaries in which the researcher questions her ability to carry out a study of good quality and is satisfied that supervision provided the support needed to do so. I obtained informed consent and the benefits, costs and reciprocity were spelt out in the reasons for the study at the beginning of each interview. Nadine specifically stated she hoped her story would be of help to others and would serve to bring about better counselling services. Issues of harm and risk, honesty and trust, privacy, confidentiality and anonymity will be further addressed elsewhere in this chapter. The question of intervention and advocacy is the basis of this research as I strongly believe there is a need for proper counselling services to be provided and the intention is that this research will serve, in a small way, to highlight this need.

Finch (in Hammersley 1996: 173-174) notes that there is a real exploitative potential in the easily established trust between women in interviews. She found as a researcher, women based their trust in her mainly on the fact of her status and demeanour as a woman. She says this makes women especially vulnerable as research subjects. As Finch notes these interviewing techniques can be used effectively to obtain information (some of it very private) which can be used ultimately against the interests of the women who gave it freely to another woman with whom they found it easy to talk.

It is clear that these concerns apply to this undertaking. The considerable controversy and debate surrounding abortion may result in data being used to support an argument for which it was not intended (Daily Dispatch 4 July 1994: page unknown).

Thus women who participated in the hope that their experiences might be of some use to other women or to better counselling facilities could be unhappy to find their views being used to support opposition to abortion. Miles and Huberman (1996: 295) also raise this issue of the use and misuse of results as an ethical issue.

For this reason it is essential for the researcher to be honest about her own views and reasons for the study. If research is interpreted to support an opposing view it is then beyond the control of the researcher.

Channels (quoted in Lee 1993: 206) develops these points further and says researchers should think through the potential results of their work and should anticipate potential distortions and misinterpretations and consider ways of presenting analytic complexities.

Lee (1993: 208) speaks of the role of trust in the data collection process and says one view is that it has an emergent nature.

> The establishment of trustful relations depends on the quality of the interpersonal engagement between researcher and researched and the building over the course of the research relationship of increasing levels of fellowship, mutual self-disclosure and reciprocity (Lee 1993: 208).

Gregg (in Riessman 1994: 53) speaks of her non-judgemental acceptance of her pregnant respondents which created a climate and space for them to share their intimate stories. She empathised with their joys and fears but suppressed her inclination to provide support or reassurance. I struggled with this aspect of not being able to provide support but felt sufficiently satisfied by being able to share information objectively from the literature where a respondent was clearly lacking in understanding. For example, women feel isolated due to the secrecy associated with abortion and experience their emotions as unique whereas if they can understand that it is part of

the process of healing it may help them to be less judgemental of themselves. For further discussion on this see Section 3.2.7. In line with Brannen (in Lee 1993: 106), however, the researcher would have to question the need to help and what her motives were as her needs may not be those of the respondent. While each has a unique experience there is a great deal in common with regard to responses but many women do not know this as abortion is such a secret, such a taboo. It is not spoken about and there is a dearth of literature. I do not believe this was detrimental as I believe this led to additional discussion and greater disclosure.

Lee (1993: 106-107) says interviews on sensitive topics can be distressing for the respondent and stressful for the researcher but states further that the depth interview can often be a cathartic experience for respondents.

Confidentiality is another issue that had to be addressed in this research. Lee (1993: 179-182) speaks at length about the difficulties of ensuring confidentiality of qualitative data. In order to protect the identity of respondents, I used pseudonyms. No concrete details were changed but where the respondents referred to their places of work these were made more vague as it could be easy to deduce information based on this. The fact that the city where the research was conducted is small further complicated the issue of confidentiality.

Miles and Huberman (1996: 297) say all ethical considerations have obvious implications for analysis and the quality of conclusions. They say dealing with ethical issues "effectively involves heightened awareness, negotiation, and making trade-offs, among ethical dilemmas, rather than the application of rules".

3.2.4 The sampling procedure

I interviewed five people, two of whom were known to me and the remainder were obtained through a non-probability sampling technique which combined snowball and purposive methods because this was the most appropriate considering the fact that people are not generally willing to be open about abortion (Rubin and Babbie 1989: 232-233).

Grinnell (1993: 162) says with non-probability sampling the probability of selection cannot be estimated so it cannot claim to be representative. He, however, points out there are many situations where it is impossible to draw a probability sample and this method is the only alternative. It is clear that the secrecy of abortion makes it necessary to use this technique.

Dooley (1995: 113) says a snowball sample is useful when it is "impossible to identify beforehand all those who will fall into your category of interest". In this way you start with one or two informants and get them to refer you to those who will be likely speak to you.

Dooley (1995: 136) says in purposive sampling - also known as judgemental or theoretical sam-

pling (Grinnell 1993: 162) researchers - choose respondents because of certain characteristics, and in this instance it is those women who have had abortions and were prepared to speak about their experiences. Rubin and Babbie (1989: 229) say it may sometimes be appropriate to select the sample on the basis of the nature of the research aims, in this case, as stated, abortion.

One respondent contacted me after I asked a weekly newspaper to run a story requesting women to come forward. A request to a general practitioner to ask women to come forward produced no responses although this avenue could have been pursued more vigorously.

The criteria for inclusion in the sample were not specified because of the nature of the sampling method used but it was anticipated it would exclude the experience of women who had abortions because of poverty. It also obviously excluded women who were not prepared to speak about their experiences. The sample also intentionally excluded women who had abortions as a result of rape, incest, health risks or foetus abnormality as the dynamics are usually different under these circumstances. There was no precondition for inclusion in the sample. Respondents needed to be conversant in English so that I could conduct interviews.

The time which had elapsed since the abortions ranged from three years to 21 years.

As with Winn (1988: 8) the interviews are not intended to stand as being representative of the experience of abortion but they speak as individuals. The interviews were more in depth than first anticipated.

3.2.5 The instruments/tools of data collection

I felt the broad themes of questions outlined in Chapter One were sufficient but as already stated, an in-depth review of the literature gave rise to additional questions especially regarding coping mechanisms and issues that would indicate greater difficulty in coping namely strong religious views, youth and so on; and whether or not information was given about the procedure beforehand.

I also believe, however, that for the purposes of this study all the necessary questions were asked and themes covered.

3.2.6 Analysis of data

The interviews were tape recorded after permission was obtained from the respondents and notes were also taken. Transcribing the tapes was time consuming and written notes were used as back up.

Bell (1996: 96) notes the time constraints of transcribing taped interviews as it can take about 10 hours. If there is ample secretarial support this is viable but in this instance, I felt it would be unethical as confidentiality was essential.

Bell (1996: 96) states that tape recordings can be useful to check the wording of statements the researcher wants to quote and to check the accuracy of the notes. It is also useful if the researcher is attempting content analysis and needs to be able to listen several times.

The researcher compared and contrasted the experiences of the respondents with that found in the literature, extracted themes around the specific questions, and thus arrived at a critical evaluation. The format is that of an analytical essay.

Miles and Huberman (1996: 8) speak of three approaches to qualitative data analysis namely interpretivism, social anthropology and collaborative social research. I will briefly look at each of these starting with the two methods I did not choose and moving on to a short description of interpretivism and my reasons for using it.

Social anthropology was not suited to this research because it makes use of multiple data sources and analytic decisions are constantly made about what information to use and which to exclude. Social anthropologists look at patterns and rules of behaviour and the refinement of theory (Miles and Huberman 1996: 8). With abortion, reactions are individualistic depending on personal beliefs and circumstance but this method does not lend itself to adequately analyse my research.

Collaborative social research encompasses collective action between the researchers and local helpers undertaken in a social setting often in the form of a field experiment. Data is collated and given to the activists both as feedback and to design the next stage of the study (Miles and Huberman 1996: 8-9). This was not suited to the purposes of this undertaking.

Dilthey (in Miles and Huberman 1996: 8) saw human activity as a text, a collection of symbols expressing layers of meaning and said human action could not be analysed with the methods of natural and physical science. An interpretation of meanings was made by both the social actors and the researcher.

Miles and Huberman (1996: 6) say phenomenologists often read and re-read interview transcripts and by being alert to their own presuppositions they can reach the "Lebenswelt" (lifeworld) of the respondent, capturing the essence of the account. They are very wary of condensing material. In line with this view, I did not condense material either and an understanding was gained by frequent re-reading of the texts. The authors say interpretivists of all types all believe that researchers are no more detached from their objects of study than are their informants. Re-

searchers have their own understandings and convictions and they will be affected by what they hear and observe. "An interview will be a co-elaborated act on the part of both parties, not a gathering of information by one party" (Miles and Huberman 1996: 6). The problem with this, the authors point out, is that if researchers use few pre-established instruments, it will be difficult to separate out external information from what they have contributed when decoding the words of their respondents. As decoding and encoding was not part of this particular research the problem did not arise.

Some of the analytic methods Miles and Huberman (1996:9) outline have been used namely noting reflections and remarks in the margins of the transcripts, identifying and highlighting similar responses and themes, gradually elaborating a small set of generalisations and creating a formalised body of knowledge in the form of theories based on these. In addition, Brannen's (in Lee 1993: 104) study says respondents accounts of sensitive topics are often full of ambiguities and contradictions and are shrouded in emotionality. In line with this, these were confronted and taken into account in their interpretation.

In retrospect, I regret not recording body language and laughter in the interviews because I believe this would have further enriched the data.

Miles and Huberman (1996: 10-11) state that their view of data analysis is that it comprises three concurrent flows of activity namely data reduction, data display and conclusion drawing and verification. Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data taken from transcriptions. The authors state that even before data is actually collected, anticipatory data reduction is occurring as the researcher decides - often without full awareness - which conceptual framework, which questions and collection processes to choose. Data reduction is part of analysis as all these steps involve analytic choices. It is a way of organising data so that final conclusions can be made.

Data display can be achieved in many innovative ways according to Miles and Huberman (1996: 11) but I have not been able to use the ideas generated by them because this is a small sample and it does not lend itself easily to display. Although the authors say extended, unreduced text is a weak and cumbersome form of display and difficult to compare (1996: 91) I have attempted to alleviate this in that responses have been placed, where possible, under the relevant questions instead of as a long unstructured story. There is, however, overlap and it was not entirely possible to break the text up in this way in all cases. This also forms part of the process of analysis. The researcher also believes using some of the suggestions, such as reducing texts, would be dangerous because of the very controversial nature of the research and the choices that would need to be made for such displays would attract criticism.

From the start of data gathering, the researcher is beginning to decide what things mean and this process is continued throughout until the final and formal conclusion drawing. "The competent researcher holds these conclusions lightly, maintaining openness and scepticism, but the conclusions are still there, inchoate and vague at first, then increasingly explicit and grounded" (Miles and Huberman 1996: 11). They have often been pre-figured from the beginning even when the researcher claims to have been proceeding inductively (Miles and Huberman 1996: 11). If the latter is indeed the case I believe this to be dishonest because for this research, for example, there was a definite hypothesis from which I proceeded.

Miles and Huberman (1996: 262-263) state that qualitative analysis can be "evocative, illuminating, masterful - and wrong". To prevent this and to test the "goodness" of qualitative research they suggest several methods of checking for representativeness of the sample (getting a critical colleague to read it over), checking for researcher effects and biases, in other words the possible influence the researcher had on respondents, weighting the evidence and deciding which data can best be trusted. The authors say checking for "unpatterns" can provide a lot of evidence such as checking the meanings of "outliers" or exceptions and extreme cases and following up surprise findings by reflecting on the surprise to the violated theory, considering how to revise it, and seeking evidence to support revision (1996: 269-271).

Another step to check the analysis is to look for negative evidence that disconfirms findings. Miller (in Miles and Huberman 1996: 271) says "disconfirming instances should be handled with care" because discarding an original hypothesis too quickly or modifying it too hastily to accommodate the negative evidence are both undesirable. The proportion of negative evidence should act as a guide. I am satisfied that attention has been given to all these steps to a lesser or greater extent where applicable in the course of this research.

Further in the quest for reliable analysis is the verification of rival explanations although Miles and Huberman (1996: 274) say there are time constraints with this. The fact is, however, that during the literature review phase this is already taking place. One of the most logical sources of corroboration are the respondents and this can take place at the data collection stage when an hypothesis can be checked out with an informant. Efforts were made in this study to do so but time and accessibility constraints placed a limit on this in the final stages. The research was given to numerous independent sources for feedback, however. In addition the respondents were asked for their own suggestions of counselling requirements during the course of the interviews and this information has been recorded and commented on.

Miles and Huberman (1996: 277) pose the question how will anyone know whether the emerging findings are good namely possibly or probably true, reliable, valid, dependable, reasonable, confirmable, credible, useful and so on. I believe that this research has addressed many of the complex variables inherent in the study and the fact that the interviews have not been condensed allows for readers to make up their own minds. Issues of objectivity, reliability, internal and external validity have been addressed. The data rings true and is plausible but areas of uncertainty have been identified and other explanations have been actively considered (Miles and Huberman 1996: 278).

3.2.7 Limitations of the study

Bell (1993: 95) notes that there is always a danger of bias creeping into interviews and Borg (in Bell 1993: 95) says this can be because the respondent wants to please the researcher; there may be a vague antagonism between them; or more importantly "the tendency of the interviewer to seek out the answers that support his preconceived notions".

Being constantly aware of this, in view of my belief that the scientific literature underestimates the effects of abortion, I continually questioned the emphasis. I support Gavron (in Bell 1993: 95) who says: "It is difficult to see how this (bias) can be avoided completely, but awareness of the problem plus constant self-control can help."

I thus had to be careful that I did not exaggerate the effects either. This is especially relevant in the current climate in South Africa where abortion has only recently been legalised and therefore the possibility exists for the proponents to attempt to minimise the effects in order to justify the legislation in the face of opposition.

I believe one off interviews are insufficient to gain all the information required because each respondent is different. I also believe a straightforward interview may not produce total honesty. Respondents require different approaches and counselling skills of engagement, acceptance and empathy are required to put the person at ease and to build a level of trust needed to discuss an emotionally charged and sensitive topic such as this.

One respondent (Kim) did not want to read over her transcript as she was happy at the time (nine months after the interview when she returned to the city on holiday) and felt she had put the abortion behind her but asked a third party who knew her story to read it over. My concern about honesty and openness were in this instance allayed, as the third party said the transcript contained more information than she had been told. Kim's interview was also the most detailed

Douglas (in Miles and Huberman 1996: 268) note that regardless of the degree of trust present, people nearly always have some reason for omitting, selecting or distorting data, and also may

have reasons for deceiving the researcher (not to mention themselves). If enough has been done to validate the data, however, more confidence is justified.

Some respondents were harshly self-critical of their actions and I felt it was necessary to comment that they were perhaps being so in order to introduce some objectivity and to indicate that alternative perceptions could exist other than the negative and judgemental. This was important for two reasons: firstly because, where these feelings were genuine, I felt a certain ethical responsibility towards the respondents; and secondly, to elicit honesty because respondents could have felt that this negativity was socially expected in view of the strong condemnation of abortion which exists in some sectors of society. The latter would directly affect the findings of the research.

Lee (1993: 105-106) notes that interviewing about sensitive topics can produce high levels of distress in the respondent which have to be managed but Brannen (in Lee 1993: 106) argues that faced with such distress interviewers may want to help but should strongly question their motives. She suggests that such feelings on the part of the researcher "often have more to do with helping the helper than those who are in need" (in Lee 1993: 106). Lee (1993: 105-106) notes that all that may be possible in such situations is for the interviewer to endure and share the pain of the respondent. I have already referred to this concern under ethical considerations (3.2.3) above.

Other limitations are those inherent in any type of research undertaking. Hyde (1994: 184-185) in reflecting on her own research, said she wanted to identify the techniques, struggles, "things I wished I had known" for the benefit of other researchers. She wanted to "confront...the myth that research is an unblemished process". She says those predisposed against the researcher's purpose or method can use admissions of imperfections in planning to attack the person or process. She takes comfort, as do I, from Van Maanen (in Hyde 1994: 185) who says:

> Accident and happenstance shapes fieldworkers' studies as much as planning or foresight;...impulse as much as rational choice; mistaken judgments as much as accurate ones. This may not be the way fieldwork is reported, but it is the way it is done (Van Maanen in Hyde 1994: 185).

3.3 CONCLUSION

This chapter has examined how the research was undertaken as well as some of the problems experienced which are typical of those found in a qualitative study. I am satisfied, however, that the study is essentially sound and replicable. This is supported by the fact that the findings support the non-positivist literature and this is sufficient to appease me that this work is not overly flawed.

CHAPTER 4
PRESENTATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter will review and discuss the major themes of the respondents' interviews and how these relate to the literature with special reference to counselling needs. The purpose of this is to identify and have respondents assist in identifying what type of counselling helped them and what would be helpful to women who are considering an abortion. The goal of counselling is to assist women to make a decision that is right for them individually after they have thoroughly considered all their options and then help them come to terms with any mixed feelings afterwards. The structure will be similar to Chapter Two and will follow the framework of the interviews using the questions as headings. I have used pseudonyms to protect the identity of the respondents.

4.2 DISCUSSION

a. How long ago did you have the abortion and how old were you at the time?

The period of time that had elapsed since the abortion ranged from two to 21 years: Kim, two; Nadine, four; Rachel, eight; Jill, 15; and Mary, 21. Two respondents, Mary and Rachel, had two abortions. Mary had hers eight years apart while Rachel had hers within months of each other. At the time of their abortions the respondents were between the ages of 16 and 27: Mary, 16 and 24; Nadine, 20; Jill, 22; Kim, 24; Rachel, 27. All had first trimester abortions which according to Adler et al. (1992: 1200-1201) is likely to have less negative effect than later terminations. The length of gestation was as follows: Nadine, 10 weeks; Rachel, seven weeks and 10 weeks; Jill, seven or nine weeks; Mary, eight weeks and unknown the second time but within the first trimester; Kim, eight weeks. Only Jill has since had a child while Rachel has had a "devastating" miscarriage. None of the respondents are married and their current ages are Jill, 37; Mary, 36; Rachel, 35; Kim, 26; and Nadine, 24. It is worth noting that two of the respondents, Jill and Nadine, provided the dates of their terminations while Mary referred to the months of the abortions and the months her child would have been born. Rachel also referred to the months of the abortions.

At the time of the termination, abortion was illegal in South Africa. Of the seven abortions, four were obtained legally in England, with two respondents, Nadine and Mary, flying there specifically for the operation while Rachel was there on holiday. Jill and Kim both had humiliating experiences attempting to obtain an abortion and while Mary's second abortion was self-induced her later interaction with the medical establishment did not appear to be as negative as the experience as the other two. While Kim and Jill's abortions were illegal, the method used was

the same as those used in England and Kim was treated with dignity. Mary's second abortion was the most dangerous as she attempted to abort herself using quinine tablets, and requesting an IUD after the specified time had elapsed which resulted in haemorrhaging and her hospitalisation.

Rachel, Jill and Kim were all opposed to abortion before seeking terminations and this has been highlighted in the literature as a factor likely to contribute to negative future coping as does a negative experience of trying to obtain a termination (Adler et al. 1992: 1197). The fact that Jill and Kim both remember their humiliating experiences vividly is an indication that this had a lasting effect. Mary and Nadine had to travel overseas and although Mary is more at peace with the first, this may be related to other factors such as being removed from the decision-making process. Although Rachel obtained legal abortions she was away from her support systems and in the second instance was 10 weeks "and I was aware of being pregnant". Kim was also angry that she had not been able to have the abortion at three weeks. "It would have been far less traumatic and quicker and more painless...what is three weeks, it's nothing."

Although younger women with no children are associated with a negative response (Adler et al. 1992: 1200-1201), this study, because it comprises a small sample, does not allow for any comparison between age groups. While Dillon (1990: 31-32) notes the negative implications for women having abortions while still in their teens this does not seem to apply to Mary who had her abortion at 16. The fact that she feels the decision was made for her, has apparently allowed her to cope with it better because she does not feel responsible. This, however, did not prevent her reacting emotionally to it some months later (being unable to look at babies and pregnant women) which seems to lend support for the emerging view that the nub of the issue is about the loss of a potential child (Neustatter 1986: 105; Winn 1988: 47, 117). Mary acknowledges greater pain over her second abortion but this could also be due to self-blame as she believes she should have "learnt (her) lesson": the abortion was illegal, self-induced and traumatic. This is consistent with the literature which says self-castigation may be greater after a second abortion (Davies 1991: 200). This applies to Rachel as well.

Although women who report little difficulty in making the decision are said to cope better (Adler et al. 1992: 1200-1201), this does not account for women who block consideration of other alternatives and whose immediate response is of wanting to be "rid" of the pregnancy as was the case with Jill, Kim and Rachel. Mary (in the first instance - and this could also explain why she has coped better with the first abortion) and Nadine both considered and initially wanted to keep the baby. This might also explain why Nadine feels she has coped better than she thought she would. That, however, contradicts the assertion of Adler et al. (1992: 1200-1201) about negative coping expectancies being associated with a negative response.

From the above, it becomes clear that the variables involved in a woman's ability to cope with abortion are complex and conflicting and that reactions are highly individualistic. It is thus essential that counselling be tailored to the needs of the individual.

Given the above, it is impossible to allude to general trends, especially in a small sample such as this, but it is necessary to be aware of the range of possibilities that exist and which have been highlighted.

b. The nature of your relationship at the time.

The relationships of the respondents ranged from long standing (Kim, five years) to a one night stand (Nadine).

Jill was in a new but serious relationship in England which was also her first, her boyfriend was three years younger than her; Rachel had been going out with her boyfriend, who was five years younger than her, for a year and had followed him to England, he was the father in both instances; Kim had been going out with her boyfriend for five years, it was her first serious relationship but it had been troubled by his infidelity; Nadine had ended a serious relationship, went on a "wild rampage" and had a one night stand with a friend who was two years younger than herself; Mary was involved in an affair with a married man, a doctor, 22 years older than herself for whom she felt gratitude, the second time it was with someone she had been going out with and who said he wanted to marry her but changed his mind when he discovered the pregnancy.

In line with Davies (1991: 188) assertion that abortion will affect each relationship differently according to many things, and that many break down due to lack of support and understanding (1991: 50), it is interesting to note that in all instances, the respondents' relationships ended and where it was meant to save it, it had the opposite effect (Davies 1991: 188). Jill's relationship ended because her boyfriend thought she had been trying to trap him into marriage. Rachel's partner became physically abusive which relates to what Kumar and Robson (in Davies 1991: 188) say about acknowledging that termination cannot be regarded as a minor event without psychological significance for the parents "not to be". Kim speaks of the abortion excising the relationship "with surgical precision". Mary's first relationship continued until she realised she was being "stupid", and the second seems to have ended through his lack of support. Nadine was "disgusted" at the lack of support from her friend with whom she had a one night stand.

It seems clear from the above that unexpected pregnancies and the dilemma that arises from them have profound effects on relationships. There is a strong possibility that these relationships may end.

c. Your feelings and those of your partner when the pregnancy was discovered.

The main focus of this question is women's feelings. As stated in Chapter Two, men's feelings are beyond the scope of the study but this is an area that requires further attention.
Research has found that the majority of women feel horror, shock and fear when they discover an unexpected pregnancy (Lane Commission in Neustatter 1986: 16), and this is supported by the respondents' feelings. The reactions of the respondents' partners bears out the literature which shows many men do not provide support although some do (Neustatter 1986: 25) and that most do not get involved in decision making (Davies 1991: 50: Haslam 1996: 52-53).

Rachel said she and her boyfriend were shocked by the first and it was a mutual "clinical" decision that had to be made because of circumstances. The "shock and devastation" of the second, however, overshadowed it. "I cried and cried...I was absolutely shattered." Her boyfriend's withdrawal from her is indicative of his own shock. She had to "sort it out". She was angry with him but "no longer feels anything".

Kim said her pregnancy was her own "fault" because she was not using contraception. Her boyfriend was "shocked and devastated" while she felt it was "a total disaster": the "worst thing that had ever happened to (her)". Although he offered help she was in effect on her own: he expected support from her and this made her angry.

Jill said she was "terrified", she and her boyfriend were in shock. "I felt so ashamed that I had gone overseas for a year and come back alone and pregnant." When he said he did not want to get married but she should not have an abortion, she later lied and said she had not been pregnant.

Nadine's partner had to be "talked out of committing suicide" and was no help to her. She had to be strong. He later offered financial help (it cost R13 000 including airfares) but never paid.

Interestingly Mary did not disclose her feelings at the discovery other than to say she was "fine" with the decision to abort, she appeared more concerned about her mother's reaction. Reading the transcript it is notable that, although she thanked me in a telephone call afterwards saying it was the first time she had talked about her feelings, the transcript is devoid of specific feelings. While there are descriptions such as "I should have learnt my lesson, I should have known better" which indicate a level of self-blame and castigation, it is not described as a feeling. Mary had "not even thought" in terms of pregnancy, it was not a word she "fully comprehended" and said when she looked back, she thinks "he must have been crazy". Her lover's response was different in that he took charge of the situation to ensure his infidelity and reputation as a doctor

would not be discovered and insisted on the abortion: his actions appear to have been based on self-interest. Mary said the second time her overriding concern was to keep it a secret.

It appears the discovery of an unexpected pregnancy also causes men to react with horror, shock and fear (Lane Commission in Neustatter 1988: 16) and thus it may be necessary to offer them support and the opportunity to think through options logically as well. This could be problematic, however, because men, simply by the fact that they are physically removed from the experience of pregnancy, appear in many instances to find it easier to simply take flight as Mary's second partner did.

From the above it seems clear that both men and women may react with horror, shock and fear when faced with an unexpected pregnancy. Counsellors will therefore need to address the issue to assist them to overcome this and make a reasoned decision.

d. Making the decision.

Although making the decision to have a termination has been described as agonising (Davies 1991: 44-45; Winn 1988: 43) only one respondent in this sample, Nadine said it was still an "incredibly difficult decision" because she wanted to keep the baby. It was her parents who "brought (her) down to earth" regarding her romantic fantasies about what it meant to have a baby. They felt an abortion "would give (her) a second chance". She said practically she could not get emotional because it would "tear her up" and the time in which to decide was very short. There was no information available about how long she could wait. A local gynaecologist arranged for her to have the termination in England.

Rachel and Jill both acknowledge a sense of denial and Rachel, Jill, and Kim all had an urgent need to be "rid of" the pregnancy, not wanting to acknowledge it. For Mary, this happened with the second pregnancy. She did not think of the implications or the fact that she was 24, self-supporting and "so what if my mother was angry". "None of that crossed my mind it was just I've got to get rid of this. It was like a panic, an absolute panic." Rachel said it was a decision that had to be made and it was all "very nice and clean and easy". It was "not a good time" for them being away from their support systems and they had saved "so long" and wanted to travel. The second time she was still in the same circumstances. Her boyfriend had begun to hit her and although she was "terrified" she was "clinging to the relationship as a support in a foreign country". She felt she could not come home and get a job being pregnant. "I didn't want to do it but I thought I had to...I couldn't cope with it on my own, I was a mess."

Jill said she did not "really consider all (her) options". She was "not really thinking very clearly". Once she knew her boyfriend did not want to get married, she knew she would have an abortion, she could not face it alone. She therefore would not allow herself to acknowledge that she was

pregnant because then she would have had to confront what she was doing. The literature indicates that it can be destructive for a woman to go through the ordeal without exploring her feelings and it can mean she does not face up to what she is doing until afterwards (Winn 1988: 47).

Kim also says the decision was not something she "really weighed up". She did not want to get married. She had to "get rid of it right now". She had never felt "so threatened"; she realised then that "if you fall pregnant you're on your own. There's nothing that can protect you from the world".

Mary said the decision was made so fast the first time. Her lover persuaded her mother that an abortion was the best solution and he would pay for it. Her mother suggested adopting the baby but the doctor insisted it should not "ruin her life". The second time she could not go back and tell her mother she had made a mistake eight years later. She should have "learnt (her) lesson" and known better. There was "no way" she was going through it alone. She had not even thought of it as a pregnancy, "it was just abort, get rid of it, it became easier". Mary says it would have devastated her mother and she could not "put them though it again". Although she says "it was so much easier the second time around to make that decision" she later contradicts this by saying it was "very difficult going through it" but worse was the "absolute terror of my mother finding out". Three years later when she met the father he said a child they saw could have been theirs which is an indication men also have anniversary reactions (Dillon 1990: 26-29). He said they could have lived together for six months to see if they wanted to get married but she said if he had not wanted to she would have had to face it alone. She is "not particularly happy" about her decision but she made it and "has to live with it".

These vignettes support the literature that the decision is seldom fully informed (Doherty 1995: 9) or a fully conscious weighing up of the woman's and other's needs (Nathanson 1990: 5); the mother is disturbed (Doherty 1995: 9) and there is the difficulty of making a balanced decision in a matter of weeks (Doherty 1995: 9; Haslam 1996: 40).

Although the literature states that the waiting period is difficult because of the growing foetus and worries about the actual operation (Haslam 1996: 130-133) none of the respondents appeared to be concerned about the latter as it was a means to an end, the pregnancy had to be "got rid of". It may be that women who come from a country where abortion is illegal find that information about the procedure is low on the list of their priorities when the struggle is about actually obtaining an abortion, and a properly performed one as opposed to a backstreet termination, even without the relevant information, is enough to ease any concerns. In line with the literature above, however, the waiting for both Kim and Rachel (the second time), was difficult

because they were both "aware of being pregnant". Kim had morning sickness and Rachel said she "felt pregnant". Nadine also had "terrible" morning sickness and said it was "horrible". Kim was angry the wait was so long: six weeks from the discovery of her pregnancy at two weeks. Jill had dizzy spells but it remained otherwise unacknowledged.

The general trend among respondents seems to be that the decision is made in haste without a thorough consideration of the options and that denial and a desire to be "rid" of the pregnancy takes precedence. Where some thought is given to keeping the baby, coping seems to be improved and this supports the above.

e. Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?

Research indicates that women heal, physically and mentally, more quickly if they know what they are about to go through (Davies 1991: 72) and many women find it more traumatic because they have no idea what to expect (Davies 1991: 72; Neustatter 1986: 53). Some want information (Neustatter 1986: 77) while others do not (Haslam 1996: 107). In line with this Nadine said the procedure was explained to her by the doctor. She wanted to know and this made her feel secure.

Mary said at the time she was "too young to fully comprehend", she may have been told but it "did not mean enough to register". Interestingly today she says she would want to know if the foetus suffers. If she had had a legal abortion with the second then she would have wanted "to know everything". Self-esteem plays a role in this regard as will be seen with Kim who felt she "did not deserve" to be treated well because she felt like a "criminal". She felt they should just "do whatever, I'm nothing". "I'm this terrible person...I should be like a piece of meat and be put on the table." This is in contradiction to how angry she was at being humiliated by other doctors and is indicative of the ambivalence and conflicting emotions of women seeking abortions and which need to be addressed in counselling. Her desire to write and thank the doctor for his compassion two years later which she did not do because "in many ways I don't feel important enough" also highlights self-esteem problems which will need attention.

Kim was told about the procedure (and was given 24 hours to think about it) and was grateful to the doctor for treating her with dignity after her earlier humiliating experiences. He told her to think about the "big picture", that she would have to live with her decision and even though she may not regret it, she might end up not having children at all and regretting that.

Rachel did not answer this question in full even though she was asked to on the transcript she was given to read. I believe the devastation of a second pregnancy and abortion so soon after the first has overshadowed other aspects that may or may not have had an impact. Being a legal abortion in England she may have been satisfied of its safety or she may have been given rudi-

mentary information. She said she was warned how it might affect her but it would not have made a difference the first time.

Jill was told it was the "latest suction method" used in England so she knew it would not be dangerous. She does not remember worrying about it. She was not told how she might feel and did not know if this would have made a difference anyway because she blocked future thoughts and told herself she would "just have to live with it".

There does not seem to be any trend evident from these questions because respondents had a variety of experiences. There is limited proof to support the literature that being told about the procedure is important. None were told how they might feel but the literature has identified this as important.

f. The abortion itself.

Rachel, Mary, Nadine and Kim all say they had general anaesthetic and D&Cs[3] while Jill's "suction method" was probably the vacuum aspiration method. Jill recalls saying "Oh, God, oh, God" throughout. It is possible to hypothesise that being awake throughout the procedure could cause additional trauma. This has implications for South Africa because in most cases the patient remains awake (SANCCFW 1997: 3).

The way a woman is treated by medical personnel contributes to her coping (Clark et al. in Neustatter 1986: 94-95; Winn 1988: 57-74) but the reality is that many women are "punished" by the medical establishment and treated in a judgemental manner (Neustatter 1986: 34, 49, 51). Haslam (1996: 146) says women seeking abortions are often "emotionally very brittle" so they take off-handedness personally. I believe that, while this is possible, the attitudes of doctors and nurses do have a major impact.

Rachel remembers the second abortion as a "horrible experience". She said there was "a subtle contempt" for the women by nursing staff and while the care was professional, it was "not that good". The fact that it was her second and she was "devastated" by it, may have coloured the experience, however, the first time staff treated her "very kindly" but this could also have been because she felt she had made the right decision. On the other hand the first abortion was at a private clinic unlike the second which was through the NHS.[4] The fact that Rachel had no support and had to find her way using a map added to the trauma. "I was crying, sobbing my heart

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3. D&C. Dilation and curettage. This is a gynaecological procedure used for abortion and other conditions such as heavy periods. The cervix is dilated and the doctor uses an instrument called a curette to loosen the contents of the uterus, removing the foetal tissue with forceps. There is another abortion procedure known as a dilation and evacuation (D&E). The cervix is dilated so that a tube can be passed through into the uterus. The other end is attached to a vacuum aspirator which sucks out the foetal tissue (Davies 1991: 216).
4. NHS. National Health Service. The state-subsidised free health service in Britain.

out and I had nobody to confide in...My lifeline didn't want to know, he had distanced himself so I got there being distraught." Rachel's experience further lends support for my view that the rendering of service should be pro-active and service providers should assess what support systems clients have in order to meet individual needs.

In line with the literature above both Jill and Kim vividly recall the "callous manner" in which they were treated by doctors. Kim described an examination by a doctor as "not quite on". "It was like if you have an abortion...you are suddenly just dirt". Kim's gratitude to the doctor - "to this day I don't know why I was so lucky to be treated so well by this man" - who treated her with dignity is notable because it is out of proportion to reality: he was doing no more than one would expect from an ethical doctor. These cases, however, illustrate the effect of doctor's attitudes and provide additional support for the literature above.

After being roughly examined by a doctor, Jill was told she might die and her memory of a thoughtless comment by the doctor who performed the abortion that she should "lose weight and get a tan" on an occasion which was one of such magnitude to her, further highlights the emotional and psychological damage doctors can inflict. Years later when a doctor told her she might not be able to have children as a result of the abortion, she felt he was trying to punish her. Kim says it became "impossible to see a doctor"; she had a "total phobia".

In comparison, Nadine had only praise for the staff, including nuns, at the abortion clinic who "went out of their way to be kind" even sending a South African nurse to make her feel comfortable. Of all the respondents, Nadine appears the least affected by the abortion and even though she described it as "the most difficult day in my life" with her emotions and thoughts "running wild", this treatment could be partly why. It also supports the literature that says psychiatric damage can nearly always be avoided and found that the attitude of those around the woman to be extremely important (Clark et al. in Neustatter 1986: 94-95).

Mary also remembers being treated "very well" the first time which could also account for her perceived better coping. She said it was exciting for "a naive 16-year-old" being in London and having a television and phone in her room. "The life inside of me meant nothing to me. It was this wonderful experience of being in London." The second abortion resulted in a haemorrhage which was traumatic because she became weak and began to panic she was going to die alone. She kept the loop as a souvenir to "remind me not to be stupid again".

It is noteworthy that both Mary and Nadine considered keeping the baby, both were treated well by staff and both have appeared to cope better. It would thus appear the variables of a consideration of all the options, plus being treated with respect and caring by the medical profession may play a role in coping.

It is clear from the above that the attitude of medical personnel had a major impact on the respondents and those who had a negative experience (Jill, Kim and Rachel, second instance) coped less well than those who were treated kindly (Nadine, Mary and Rachel, first instance).

g. Your feelings afterwards, immediately; several years later; after having children.

The respondents' feelings are in line with the literature which says feelings and reactions are as diverse as they are unique ranging from mixed feelings (Haslam 1996: 7; Neustatter 1986: title) to feelings of loss and regret to repression of sadness because it is seen as inappropriate (Winn 1988: 103). Nathanson (1990: 5) says she did not realise how profoundly she would suffer. There is evidence of profound effects amongst all the respondents: Nadine says: "You never forget you have had an abortion." Rachel says: "It's left its mark". They identify feelings of worthlessness (Jill, Nadine and Kim); of being "permanently flawed" (Jill) (Neustatter 1986: 91); of permanent change in themselves (Jill and Kim); and of loss and regret (all respondents).

Three of the respondents (Nadine, Mary and Rachel) refer to making conscious decisions to "pick (themselves) up and get on with (their lives)" while Jill recognised the need to talk about her experience. These could perhaps be individual coping mechanisms but the decision to "pick (themselves) up" might also have been a way of putting the issue aside and not dealing with it as evidenced in Mary's statement: "I just wanted to get it over with, I just want to forget about it and put it out of my mind." This needs to be identified by counsellors and addressed.

Reactions and behaviours are also in line with some of the "symptoms" of PAS as described by Dillon (1990: 20-29) but I regard this more as a useful checklist to identify problems that need to be addressed in a treatment plan rather than an acceptance of this label.

The PAS "symptoms" of guilt, suicidal thoughts (Jill), broken relationships especially with the father (Kim "could not bear" her boyfriend to touch her"), dreams about babies (Jill, Kim and Rachel), trigger events such as the later birth of a baby (Jill), anger, loss of self-esteem (Mary, Kim, Jill), destroying the clothes worn to the clinic (Jill), inability to relate to men (Kim), difficulties with other people's babies (Mary), anniversary reactions (all respondents), looking at children the same age (Kim: "You'll always have that"), memories of the procedure (Jill said she thought she would remember the suction sound "all her life"), attempts to atone (Kim "paid her dues" through work, Jill sponsored a child) are all described by all the respondents to a greater or lesser degree (Dillon 1990: 20-29).

In line with PAS "symptoms" Kim seems to have been in a state of shock similar to post-traumatic stress. She changed her style of dress, was unable to see a male doctor, could not display any sexuality and was "revolted by people kissing" (she froze and then flushed her two goldfish

down the toilet when they appeared to begin mating). Sex "had consequences" and this made her angry. "Sex is romantic and love but sex makes babies and once I was confronted by this harsh truth...I was quite disillusioned and disgusted with the whole thing." She also needed to "reclaim" her body after being "poked and prodded" during the course of examinations. She said having an abortion was "like making a decision about not being a woman anymore". She "changed completely" and became "a different person". Her "whole idea of relationships also changed fundamentally". She now looks for a friend, a partner and a more "oatmeal' kind of relationship as compared to a romantic idyll.

Three of the respondents, Rachel, Kim and Jill, spoke of emotional numbness after the abortion and in Kim's case this appears to have been quite extreme: she did not want any emotional contact with anyone. Rachel said she was "like a zombie". This numbness is cited as a negative effect by Kent (in Dillon 1990: 43). Saltenberger (in Dillon 1990: 13) says it is only in recognising their repressed grief and guilt that many women are able to make progress. Davies (1991: 16) states that unexpressed feelings and questions will remain an undercurrent of everyday life until they are understood and resolved.

The importance of mourning is outlined in the literature (Neustatter 1986: 105; Winn 1988: 47, 117) and the fact that it is an issue for the respondents is clear. It also provides an indication of their level of recovery. All except Kim said they had mourned, albeit 12 years later in Jill's case. Nadine "allowed (herself) to grieve...you had a child and you lost it". She does not "burst into tears anymore" but her ambivalence is summed up in her words "I have to forgive myself...and sometimes I do and sometimes I don't." Rachel said: "I mourned the loss and had so many regrets. I cried a lot...and begged for forgiveness...I don't get emotional or upset anymore but inside there is a sense of loss." Kim said there was "no escaping the regret...I regretted it when I saw my fiancé's ex with her baby." Mary, although not referring to specific feelings, speaks of anniversary reactions (Dillon 1990: 26-29) remembering the abortion months and the months her children would have been born which is indicative of regrets and sadness. Kim, however, feels mourning is "self-indulgent" and "a luxury". "Get real, it's melodramatic. I've been crisp and controlled from the beginning." She does, however, indicate some insight as evidenced in sometimes feeling "sad and empty". She had never cried except for the day after. "Maybe I am still hard on myself, it will take awhile. I have to live with the choice." She had dealt with the fact that she had had an abortion "to a large extent and obviously you never completely deal with it".

She became angry when I inadvertently referred to the "baby" and said people had "no right to assume" the foetus was a baby. I believe she is using denial and repression and a refusal to allow herself to mourn in order to cope. Her anger at my referral to the "baby" indicates she may not want to acknowledge this potential because she perhaps has some insight to the pain that will result. This is supported by the fact that she felt upset after the interview and her refusal to read the transcript. My impression is that, having made the decision, she does not feel she has a right

to mourn. The implication for counselling here is that women must be given permission (Winn 1988: 47, 117) to feel sad and mourn their loss.

There is a theme amongst respondents of having disappointed parents. Kim felt she had let them and herself down: she had always been the person who "did the right thing". "I hated fucking up, the feeling of I'd made a mistake, I've made a mess, it was terrible." Nadine said her parents had "put her on a pedestal" because she had always achieved and now they were disappointed.

Self-esteem problems identified under Section e above can be seen again in Kim, Nadine and Jill who all speak of feelings of worthlessness as a result of what Nadine describes as "doing something terrible". "You don't deserve to be happy. I've always had self-esteem problems." Jill speaks of thinking of suicide in the context of her worthlessness: she did not care if she died, "it would mean nothing". Kim became reclusive and worked long hours. "It was like I had nothing to give to the world and nothing to ask from the world." Mary and Jill both castigate themselves for the abortions. Mary said there was "always the possibility" that she could have another abortion because she is a "veteran" at it while Jill wonders "what else am I capable of". This theme of worthlessness and self-castigation provides an indication that an important area of post-abortion counselling would be to focus on self-esteem issues.

The finality of abortion is implicit in these statements. Jill said there was "no turning back the clock" and Rachel said it "could not be undone". Jill said the abortion "coloured her whole life and changed it forever"; she had a "permanent flaw". Over the years she had come more to terms with it but it would always be a part of her. The birth of her son 12 years later triggered her regret and feelings of loss and this is in line with the literature which speaks of reactions being delayed for 10 or 20 years (Blacker 1995: 48, 59: Levin 1997: 9; Neustatter 1986: 108; Sutton 1995: 59; Winn 1988: 7, 99), of trigger events such as the birth of a baby (Speckhard and Rue in Sutton 1995: 62; White 1995: 68) and of profound suffering (Nathanson 1990: 5). She said the "enormity of what she had done" hit her at that point as did the knowledge that she would never know her unborn child. "It was only then that I began to mourn." Before that she had felt a "terrible sadness" but had never regretted it and seen it as her only option. My supposition that Kim is side-stepping the pain could be supported by Jill's experience. The fact that having children became a complex issue for Rachel, Mary and Jill further supports this. Perhaps there is a sub-conscious realisation that the birth of a child will bring unresolved mourning to the fore - and that is possibly too painful to contemplate. The implications for counselling are that women should be warned and given support in future pregnancies. The prevailing resistance to counselling, however, makes this problematic.

Jill said after talking about the experience she had had numerous "vivid dreams" that she was pregnant and chose to keep the baby (Dillon 1990: 20-25). She also dreamt that she had lost her son on a ship and woke up crying. Kim also had dreams where she stood by and saw a murder and she did not stop it. Jill says knowing how precious her son is to her and not knowing the

baby she would have had and yet knowing her son, the regret is balanced because she has him. She is grateful she has him but it does not take the pain away.

Nadine said immediately afterwards she felt "extremely relieved it was done, the decision was made" and this supports the literature that says the relief is related to the fact that the decision is over (Dillon 1990: 3). Rachel also had a sense of relief along with sadness.

Rachel was not "too devastated" but after the second she was "devastated for months and had terrible guilt". It "hit (her) hardest" when she returned home five months later. She was "a wreck" and was taking sleeping tablets, anti-anxiety tablets and anti-depressants. I remember her as having a facial tic which later disappeared. Eight years later, having learnt "to bury it and cope in a conscious way" she "only occasionally feels sad", disappointed and a sense of loss. "It does still affect me emotionally from time to time but it is not fresh anymore." She was a "lot more reluctant" to talk about it now because she wants to "let it go".

Mary said after the first she was "fine". The same night, however, she drank for the first time and got "totally plastered". It "hit (her)" four months later. The second time her response was possibly subjugated to the fact that her overriding concern was to prevent her family finding out.

Mary said through the years she had "learnt to deal with it" because nothing was going to change it, "nothing was going to bring her child back" and in retrospect, if she had had any choice she would not have had an abortion. She is glad the decision was made for her, however, as it was "probably the best decision". For years she did not think so but now looks at how life would have been different. She had not "missed it". Her child would have been 20 years this month but "who knows how my life would have gone". I believe it is clear that she has used rationalisation to come to terms with this and the juxtaposition of the things she says - she had not missed it but her child would have been 20 - indicates her ambivalence.

Davies (1991: 146-148) says for some abortion can be both a symbolic and actual loss such as the loss of childhood innocence or the loss of a potential baby. This is supported by the respondents because Kim described it as a "complete loss of childhood". She said from one day to the next "I had grown up and it was this terrible loss...it was a terrible feeling...very harsh. I think that was the greatest loss of the whole experience...actions have consequences". Jill felt it as a loss of both: a potential child as well, perhaps, of childhood, which although she does not say it in as many words, it is implicit in her statements about the "complete change" in her. Mary did not refer to this change in terms of loss but said it was "amazing how quickly you grow up". "One day you're a naive child and suddenly 24 hours later you're an adult."

Some writers refer to the positive aspects of personal growth (Davies 1991: cover) after an abortion and it appears this did occur to some extent. Mary said it had not been easy "but you come out of it stronger". If she had her life over there was "little about the bad things...that (she) would change...for what (she had) learnt, for what it...taught (her), for how it's made (her) grow". She had become "a little wiser". Kim said it had been "empowering" for her to organise the termination. "I did not want to be an unwed mother so I did it quickly, taking control." This statement indicates that it is important to recognise individual coping mechanisms and internal personality resources and to identify these strengths to assist in the healing process. These must be acknowledged and credited so that the woman can integrate the positive and the negative of the experience.

The respondents' reactions support the literature which highlights diverse, unique and mixed reactions. The only trends that can be identified are a variety of diverse ones that emphasise individual coping mechanisms. It is clear that the respondents reacted in ways described as evidence of PAS and that a subsequent child can trigger reactions. It would be interesting had the sample included more women who have subsequently had children to test this further.

h. Did you have any type of counselling before or afterwards?

It must be noted that there is overlap between the next three questions.

Three of the respondents (Kim, Nadine and Rachel) received at best very limited counselling while two (Jill and Mary) received none at all. This is far from the ideal of non-judgemental and non-directional counselling outlined in a British Department of Health and Social Security health circular (Haslam 1996: 58-59) which calls for the woman to have a "full opportunity to make a reasoned assessment of her own wishes and circumstances". Counselling has been proven to be helpful and supportive (Neustatter 1986: 94).

It is important to note that all the women had abortions in the context of strong condemnation of abortion and thus these negative prevailing social attitudes may have played a role in the development of guilt (Ashton in Neustatter 1986: 94). Kim's statement that legalising abortion "would not change anything except that you won't feel like a criminal trying to arrange it" because society's attitudes were not going to change supports this.

Jill did not even informally consider all her options and feelings - which can be destructive (Winn 1988: 47, 106) - and, along with Rachel and Nadine, has since sought counselling. For Mary and Nadine there was some consideration of keeping the child. These cases lend support for the above because a lack of counselling has had implications for their lives and a possible reason why Jill has taken so long to confront the issue. It could also potentially explain Mary's breakdown.

Rachel, Nadine and Kim had minimal counselling. Rachel spoke to the doctor who gave her options but declined intensive counselling saying she was "100% fine and sure". The second time she was again given options but did not recall being offered counselling. The doctor had agreed that her circumstances were "not ideal". Again this illustrates the point in the literature about the need for a thorough and reasoned assessment (Haslam 1996: 58-59). It seems apparent that doctors and counsellors give support too quickly in the belief they are helping whereas the process that is needed is a thorough exploration of options. Rachel, herself, says there should be counselling before to enable women to make "informed decisions". Nadine was "surprised at receiving only five minutes" and said it was a formality: she was asked why she wanted the termination. Afterwards she was given a piece of paper telling her to expect to be "depressed, suicidal or to want to get married". Kim, on the other hand, was given some insight into how she might feel and what to expect from the operation by the doctor who also told her to think about her decision for 24 hours. It seems, however, that her gratitude to him for treating her with dignity outweighed a thorough consideration of the options. Kim, Rachel and Jill were blinded to options by their fear.

Kim described counselling as "the best", and "most beneficial...just speaking to my friend who had three abortions helped". It also helped talking to the feminists who assisted her. She later helped someone else. "I told her what to do, that she wasn't worthless and that she deserved to be treated well. I didn't even know her name." She said "you need someone to tell you to take morning sickness tablets, the highly practical things...and to tell you you're allowed to feel that it is difficult to brush your teeth and dress because it is normal". She believes counselling is important because after speaking to other women there is the realisation that abortion "is not such a strange occurrence, it is just that people do not speak about it".

There are differing opinions on who should counsel and while friends can be supportive they often try to solve the problem (Davies 1991: 101). I believe doctors are too busy to provide adequate counselling but as has been seen in the literature and the experience of Kim and Jill, doctors' attitudes can be detrimental (but in Kim's case, also helpful). Social workers too have their own biases regarding abortion and I believe this is a specialised and sensitive area of counselling that should only be provided by people who support a women's right to choose but who also recognise that the woman may experience a host of painful and mixed feelings. Allen (in Neustatter 1986: 110) established that women found it more helpful talking to abortion counsellors rather than doctors or social workers. Clearly the experience of the respondents does not provide clear direction on this aspect because of the dearth of counselling they received. Jill felt the person to counsel should be someone "neutral and unbiased" while Rachel felt it should be a "qualified professional specialising in this area". Nadine said women must be asked if they want to speak to someone and the person should be "trained in counselling" and be "completely objective".

On the question of how much counselling is needed before and after, it would seem the information provided by doctors beforehand is inadequate to meet counselling needs as described by Nadine, Rachel and Kim and this is in line with the literature (Winn 1988: 50). Some abortion clinics in England allow for an appointment up to 45 minutes and as many return visits as it takes the woman to make up her mind (Neustatter 1986: 54). Nadine felt the ideal would be at least two sessions before. Marie Stopes International on the other hand believe most clients have already made up their mind and do not believe compulsory counselling to be to a woman's advantage (Haslam 1996: 101). I believe, because Marie Stopes advocates for women's rights, it is not fully acknowledging the impact of abortion in order not to allow the pro-life movement to "propagandize and make points" (Neustatter 1986: 3) but also, the category of women who use the service could be the more educated women who will seek counselling resources elsewhere.

Rachel believes it would be useful to be able to talk about it "straight afterwards and up to a year or so later" while Nadine's belief that there should be follow up counselling with an option to go back is noteworthy. In Britain, however, few women keep follow-up appointments at private abortion charities because they do not feel comfortable returning to the abortion venue (Neustatter 1986: 106). Thus, ideally, post-abortion counselling should be provided at a different venue.

The fact that none of the respondents had thorough counselling and that they identified it as important highlights the need to provide it and supports the literature which emphasises the role and importance of counselling. The problems the respondents had coping without its benefits further highlights this.

i. What was useful, what was not?

This section did not elicit a great deal of response and this can be viewed against the fact that the respondents received very little in the way of counselling. What it did reveal, however, is further support for the fact that coping strategies are highly individualistic and what helps one woman may not help the next. The implications for counselling are that, as also already stated, a treatment plan must be tailored to the individual's needs and all possible avenues of assisting the women integrate the experience must be explored. Flexibility and an attunement to identifying the women's needs are paramount as will be the use of circular questions[5] (Fleuridas, Nelson & Rosenthal 1986: 113).

Rachel said the she does not remember but the biggest support was being able to talk about it. It was also a support talking to the other women who were having abortions. Afterwards she

5. Circular questions, as opposed to linear questions, develop an awareness of the "reciprocal interrelatedness" of behaviours. Circular questions provide a means to conduct a systemic investigation of the person's circumstances (Fleuridas et al. 1986: 113).

spoke to a clinical social worker which she thinks helped. She also spoke to "lots of friends" because she "needed to get it out".

Nadine was angered by the attitudes of the Family Planning Association (FPA)[6] who she found "extremely judgemental" because they wanted to know the length of her relationship. "There business is not moral issues, they should just give you the facts...the options and the pros and cons." This supports the literature which calls for non-judgemental counselling (Haslam 1996: 58-59). Her two experiences with a psychologist also angered her because the woman focussed on her relationship with her father instead of showing or teaching her skills on "how to deal with having an abortion". This statement highlights service requirements and underlines the need for dealing with the patient's agenda and not the therapist's.

Jill said her psychologist would bring up the abortion even when she did not want to but afterwards she was glad because she had cried a great deal and this had helped. She said she had gone to the psychologist for other reasons and the abortion "came up" which supports the literature that says more and more therapists are encountering patients who initially present for counselling for other reasons (Dillon 1990: 13, 43) and that it will rarely be exposed outside a deep trust relationship (Kent in Dillon 1990: 13). Jill said after the abortion she was offered counselling but declined because she felt so "raw" and tearful. She would have liked for the staff to have pushed her to talk because she wanted to. This may have helped her to address the issue earlier. This lends additional support to my view expressed under Section f above that service providers need to be more pro-active. A person cannot be forced but they can be encouraged with sensitivity.

Kim said a series of dreams she had a year after the abortion helped her and made her realise she did not have to "torture" herself and be "harsh and ugly" to herself all the time. The dreams were "loving and compassionate" of her. She started having the dreams a year later when she "finally started looking at boys again" and even though she "could not imagine kissing them", she knew she would like to get involved. She thought she had to because if she did not she thought she was never going to get over it. She said dreams could be helpful in counselling.

Kim said it had also helped being "confronted by babies" although this had a negative effect on Mary. Kim "hated" going to see her fiancé's ex who had a baby because she always compared herself. It would "tear her apart" but she forced herself because she almost wanted to punish herself but also "just being confronted with a baby made me face what I had to face". The baby kissed her and she described it as the most terrible feeling. "...it felt like I was going to completely crumble away". The language she uses is significant because it is so at odds with the experience: most people would regard a baby's kiss as pleasant yet she describes it as "terrible".

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6. Family Planning Association. This is a South African state-sponsored service which provides free contraception, pregnancy tests, infant innoculations and clinics to monitor the health of babies and their mothers. It also provides information and prevention programmes eg. on sexually transmitted diseases.

This gives some indication of her state of mind. The reality of the baby's mother's circumstances, however, also helped her in that she saw how difficult it was for her to manage on her own. Kim wants a baby with someone "(she) love(s) not detest(s)". She could not take care of herself emotionally or financially at the time and "it's never been that I made the wrong decision, it was too logical and too right...I've always known that this was the decision, but I've always known there is a price to be paid for this decision." Jill, however, also felt this way until she had her child. Kim said meeting her fiancé was what "really helped (her) deal with the whole issue". She did not think that anybody would love her or that she could have a sexual relationship again.

Mary said what she would have liked "more than anything" was a mediator between her and her parents. When her lover told her mother bluntly, her mother went "ballistic" and she "could not bear the thought" that she had inflicted this on her.

Due to the fact that counselling was virtually non-existent the issue of timing and the sensitive handling of the provision of contraceptive information (Haslam 1996: 23) was not an issue for these respondents except Jill who felt she had been chastised about using abortion as a method of contraception.

Contraception, however, was an issue for all of the women in one way or another. Jill used none and neither did Mary "for some strange reason". Rachel used condoms "but not always" and was "aware of (her) cycle" at other times. Nadine says she was on the Pill.

Kim said she had a "major issue" with contraception saying she had always been "paranoid" and very careful about it until something changed and she "lost control". She was not using contraception but she was "constantly trying to get it right": she would start taking the Pill and then morning after pills. Kim said when she "finally became sexually active" after the abortion she "could not use contraception". She was in a "denial stage" because of a lack of counselling. "Either you want to purposely punish yourself or you are just not dealing with the issue of contraception and it becomes a vicious cycle." She says it is crucial to deal with it or "there is a big chance there will be another pregnancy". She has since "got it under control".

Haslam (1996: 27) notes that many women are unaware of the morning after pill or IUD and in the case of the respondents, only Kim tried the morning after pill and both she and Mary used the IUD albeit too late. Jill's pregnancy fears seem to have been allayed by her boyfriend's promise to stand by her but ultimately it seemed she had a different perception of what this meant. Her unsuccessful attempt at obtaining contraception highlights the need for it to be made easily accessible.

j. What would have helped?

It is important to note that the women in the sample did not show a great deal of insight into what their needs were in terms of counselling. This is possibly related to the taboo nature of the subject, that they have no rights because they have "committed a big sin", but also because there is a stigma attached to counselling in general. South Africa has not yet established a culture of acceptance of counselling: it is seen to be only for those who have serious psychological problems as evidenced by Kim's statement that she could not seek a legal termination as she had never had any previous psychiatric problems necessitating a visit to a psychologist.

In the literature review, I outlined what has been found to be the best process of counselling from pre-abortion - namely a consideration of the options to keep the baby, have it adopted or to have a termination - to after, and outlined why each is important. As already noted the respondents had limited counselling so the benefits of counselling were lacking for them.

Nadine said having information was important and people should know "where to go to". She would not know where to go now and "what about people in rural areas". This is in line with the literature.

Social conditioning and the taboo, even today, of single motherhood is apparent in Kim's choice of words in the statement that she did not want to be an "unwed mother" as well as Jill's shame at being "pregnant and alone". Both were young at the time and this could be taken into account as well as the fact that both were not financially secure. Jill later had a baby out of wedlock but she was in a stable relationship and had financial security. Rachel also was ready to have a child later even though she was unmarried. The implication here is that if a woman is to realistically consider her options, support services, both practical and emotional, need to be in place because men often fail to provide support. The alternative is to make the laws compelling men to provide financial support more accessible.

Adoption was not a consideration for any of the respondents except Mary who said she "liked the idea" of her mother adopting her baby. Jill said she could not give up a baby for adoption.

In line with the literature (Haslam 1996: 142-143; 156-157; Neustatter 1986: 42-43; Winn 1988: 48; 50; 55-56) and my own views that abortion counselling should be non-directive but challenging, Jill said she wished someone had made her acknowledge the pregnancy and "realistically consider" all her options. "It may not have changed my mind but at least the decision would have been reasoned." Mary also said she would have liked someone to discuss her options with her - the first time. With abortion now being legal she thinks counselling would be "wonderful especially for 15 or 16-year-olds". Rachel said counselling would help the woman to make "an informed decision". This supports the literature which says a thorough considera-

tion is important (Haslam 1996: 58-59). Rachel said "it was a hard decision to make and you need all the support you can get". She felt "trapped and had no options" and described her devastation and guilt. Mary said the second time she did not want anyone to know she was pregnant. "Now I realise that if there was someone it would be wonderful to talk but at the time I was so caught up in this fear." Even then she would not have known if she could trust them, however, as they could have phoned her mother and said they feared she would overdose. The implications of this are that confidentiality and trust will be a major issue and this will need to be clearly set out. It also illustrates the ignorance that exists about the role of a counsellor and thus education is needed to combat this.

The literature states that women should be helped to decide if they have a value system that will allow them to live with the knowledge afterwards because many women present saying they do not agree with abortion but then opt for it (Neustatter 1986: 52). Jill and Kim had both been opposed to abortion and Rachel, while not being judgemental, "felt (she) would never", yet all three had abortions. This would be another reason to help explain why these respondents still display regret.

The importance of providing medical information about what to expect as well as clear up myths and misconceptions (Neustatter 1986: 53) is supported because Jill, for example said she feared she would haemorrhage and die "in the middle of nowhere", and Rachel was worried the operation was incomplete.

The literature identifies the importance of telling women they will grieve and have sad feelings because it gives them permission to do so (Neustatter 1986: 105; Winn 1988: 47, 117) but none of the respondents were told and Jill says it was only 13 years later that a psychologist said to her it seemed she had never "mourned the loss". Although Kim said mourning was a "luxury (she did) not want to afford (herself)", had she received pre-abortion counselling, this would have been established and addressed. Nadine said it would have been ideal to "speak to someone about what was going to happen to you physically and emotionally".

Rachel said it was "best to have a complete picture of what the effects may be and enough information on how to deal with it afterwards". Nadine wanted to speak to someone who had a good experience and somebody who had a bad. Rachel said it could not "be undone so you need to be as informed as possible and prepared to deal with it as constructively as possible".

Haslam (1996: 232) highlights the importance of post-abortion counselling and its effectiveness can be seen in Rachel's statement that talking was what helped her, and Jill's working through it in counselling with a psychologist focusing on grief and loss which the literature has noted should be the main focus (Davies 1991: Doherty 1995: Neustatter 1986).

Nadine and Rachel said support groups would be "excellent". Lodl et al. (1985: 127) say the value of support groups has been cited by numerous authors as serving useful purposes. Several writers (Neustatter 1986: 1; Winn 1988: 103) have also written of the positive impact of these groups. Kim believes group counselling would be "the best" because the secrecy surrounding abortion means the feelings "fester" inside. Kim says people "do not want you to heal". Kim spoke of the isolation of abortion and the realisation, after reading a book about women's experiences, that "it is a process and that most people have the same experiences and it would be useful to know that". Nadine said she would like to read more about abortion.

Although the literature reveals useful self-help techniques, little use has been made of this by the respondents and this is possibly simply because they have not had any services rendered to them.

Individual coping mechanisms, however, are again apparent. Kim was "not fine" about her ex until she found some closure recently in making him pay half of the costs. She wanted him to be responsible and "at least be able to redeem some respect in my eyes". He paid and then it was a "finished chapter".

She also found comfort in her dreams and her sister's dog. She did not have emotional contact with anyone but the dog "was my baby, I cuddled and nurtured it". It slept with her and she cooked it special meals. "I just needed to nurture something."

Mary said she wrote about her experiences although she has not written specifically about the abortion. Several authors (Davies 1991; Nathanson 1989; Townsend 1997) found it cathartic to write about their abortions.

Dillon (1990: 15) says it is problematic that there is no ritual to say goodbye to the baby which may indicate why Nadine found it calming to see a scan of her baby. I found this surprising but for her it was appropriate. This again highlights the need for flexibility and attunement to the woman's needs. Jill, on the other hand was "deeply disturbed" by seeing staff washing the remains of the foetus down the sink.

The fact that the respondents received little counselling affected insight into responses but a range of possibilities that support the literature are evident. These include a proper exploration of options and possible feelings that may result as well as the range of possible services and exercises that will assist coping namely support groups, dream work and writing about the experience were identified.

k. Who else knew, did you talk to?

Haslam (1996: 50-51) says that deciding who to tell is an important first step. I believe that counsellors should be high up on the list as the information under Section d illustrates the problems of decision making and the need for counselling to enable women to consider all their options. This is perhaps best left to objective counsellors because partners, family and friends are too close to the person.

The respondents received varying support from a variety of people but in Kim's case, for example, the feminists and her friend who helped her, did so from the point of view that she had made a decision, not from the point of assisting her to make one. "They were very supportive and they were people I could turn to because they didn't think abortion was a terrible thing...whatever I did they were on my side."

The literature says mothers can be supportive (Neustatter 1986: 45) as were Jill's, Kim's (albeit at a distance), Nadine's and Mary's (in the first instance). Rachel did not give her parents an opportunity and Mary kept her second abortion a secret although she says they would have been supportive. Kim told her mother because they were very close and she felt she did not want "something so important" to come between them.

Haslam (1996: 55-56) notes that women need parental support for practical aspects of deciding on abortion or keeping the baby. Nadine, Jill and Mary's family all assisted to a greater or lesser degree although Mary's mother initially went "ballistic". Nadine's parents suggested an abortion to give her "a second chance" and offered to pay and she could pay them back. She said it was "very hush hush" and she does not discuss it with them "because they are embarrassed by it".

Although Jill obtained the support of her family, she views this in the context of it helping her out of a predicament rather than actual support for abortion. It is an issue for her now how her mother feels about it. Her brother said she should keep the baby but this avenue was not pursued. She resented the fact that her mother's boss was told, she did not like people being in a position to judge her.

The literature revolves around telling people beforehand to assist in decision making but who to tell afterwards is also important because it can aid healing. All the respondents except Jill, however, showed a resistance to counselling although they thought it was a good idea. None spoke of seeking it out now because they considered it to be in the past but it is clear to me that their attempts to integrate the experience have only had varying degrees of success.

Kim became angry afterwards and told people because she felt they should either accept her or "scoot". She also told her fiancé because she felt "a fake" and he "dealt with it marvellously". Jill also told her boyfriend when they were about to break up because she wanted him to know and judge her if he wanted to.

Jill spoke to Lifeline once afterwards but she was told it would be unfair to disrupt the father's life. Jill said she finally told him and a close friend two years ago, the friend because she wanted to know if she should tell the father and the father because she wanted him to forgive her. "I wanted to ask his forgiveness because I felt if he could forgive me, I could begin to forgive myself." This supports the Adler et al. (1992: 1197) view that partner support and others who are close to the woman influence later coping. She feels the need to tell other close friends as she feels it is something important they should know about her. This in itself is an indication of healing because previously she was unable to. Highlighting this in counselling would help the woman to see she had made progress.

Nadine told people when there were rumours that it was her friend. She "does not make it a secret" if she has a boyfriend. She has also told friends with babies and they talk about it.

Mary only told a friend the second time but has subsequently spoken about it to other people. She has told a few friends but not many as it is "obviously not something to be proud of".

The taboo nature of the subject impacted on Rachel who had to pretend "nothing was wrong" when her boyfriend's brother's wife had a baby two weeks later. She said that "hit her hardest".

I believe the responses highlight the need for objective, non-directive and non-judgemental counselling proposed by the literature because I agree with the view that supporting the woman's right to abortion without providing her with a opportunity to explore her feelings and other options is counter-productive (Neustatter 1986: 110). This is in line with the literature which has found women cope better after a thorough exploration of options (Neustatter 1986: 94) and this finds limited support in my findings because both Mary and Nadine seemed to cope better having both considered keeping their babies.

l. Did you have any religious or moral views on abortion before the termination or after and did these change?

All the respondents had religious or moral views on abortion. Kim and Rachel were brought up in strict religious homes where abortion was viewed as "a big sin" and although none of the others had this, religion appears to have been a presence or became important afterwards. Kim and Jill were judgemental and strongly opposed to abortion while Rachel felt it was not some-

thing she would do. Nadine was "grateful before that (she) had never had to make the decision" because she was in "two minds" about abortion.

The repercussions of these views are evident. There is a sense of "letting God down" and an inability to pray or go to church (Casey 1995: 80) as described by Mary - which further supports my assumption above. Nadine talks of a "battle" between herself and God. She says she does not consider herself a Christian but one wonders if this is because she feels she is beyond redemption: her sin is too great. She immediately speaks about forgiveness after this which lends support to this hypothesis. It is significant that she says she stopped praying afterwards. "I feel like I didn't deserve that release." This is in line with Dillon (1990: 29-30) who says many see abortion as their first serious sin and the one that is unforgivable by God.

Mary makes a number of contradictory statements saying she does not and did not have any religious or moral views and cannot say she is "for or against" but my sense is that she feels not entitled to have an opinion because it might be contradictory. She also said, however, that she had always regarded herself as a Christian and the fact that she expected retribution and that she could no longer go to church because she felt unworthy is indicative of self-blame. She says she felt subconsciously "so disgraced" but she "conned (herself) out of thinking (she) did wrong": if it was "meant to be" she would have had the abortion but it would not have been successful.

Mary says she started going to church again this year after her father's death and she has now stopped "beating (herself) up" about the abortion.

She is concerned abortion will be used as a contraceptive method. She is also concerned for young girls because she says it will "screw up their minds eventually" if they do not think about it at the time. She is "a bit against making it so easy" for them. She had been strong enough to cope with it and "pull (herself) through".

Jill said she had always been opposed to abortion but it was the first thing she thought of when she discovered her pregnancy. Afterwards she "felt strongly" that women had the right to choose because society would never eradicate it and it was better than putting women through "all the trauma of seeking an illegal one". She feels ambivalent now "because it causes so much pain" and she thinks of all the loss of life. She felt she could not speak to a minister about it because she feared judgement and she could not talk about it. It was "between (her) and God".

I believe that some or all of the respondents have used denial, rationalisation and repression to a greater or lesser degree to cope with their abortions as cited in the literature (Dillon 1990: 9, 14; Rue 1995: 22). Some have said so directly. Like Mary, Jill tried to "let (herself) off the hook" in a complex and almost bizarre way by seeking confirmation that the fact that her uterus lay backwards would have prevented the pregnancy from developing.

All the respondents had religious or moral views on abortion and these appear to have played a negative role in their coping. While some changed their views afterwards, others seem to feel they have no right to still oppose it having had abortions themselves. It also appears that, faced with an unexpected pregnancy, women sometimes see abortion as the only option even though they oppose it.

m. Did your feelings about having children change after the abortion?

The question of having children became a complex issue for the respondents and this is in line with the research which strongly indicates a theme of punishment among women who have had abortions (Davies 1991: 151). Some respondents fear an inability to have children or that they will be impaired (Winn 1988: 53). The literature says some women rush into pregnancy again (Davies 1991: 200) while others avoid it - possibly for these reasons. These fears can also possibly be linked to the myths around the safety of abortion.

Rachel first said she did not want children and then said she did; Mary said she had "conned" herself into not wanting children; before having her son, Jill had begun to fear whether or not she would be able to have children; but Nadine and Kim both wanted children. Kim said she would love her child "more than anything and it would be the most important thing to (her)". A friend of Rachel and Kim's who read their transcripts with their permission offered this observation. She noted that Rachel regularly changed her mind on wanting children and had had numerous pregnancy "scares" subsequently - which may indicate a subconscious desire - and had always been "ecstatic" at the possibility. In contradiction to the interview, Kim had told her "quite vehemently" that she did not want children and would rather adopt.

Jill's and Nadine's reactions are in line with the literature on expectations of punishment. Jill said she had always wanted children but as she got older she started to worry, "almost irrationally" that she would not be able to have any. She thought she would be "punished by God". Nadine also loves and wants children but she also worries about being punished and not being able to have a child or that it will be deformed: "You expect a lightning bolt". The respondents also inflicted punishment on themselves. Kim "punished (herself)" by not taking medication to cope with her morning sickness and going to see a friend's baby while Mary does not know if she is trying to inflict punishment on herself subconsciously but she tends to choose the wrong men "deliberately going out and finding these absolute dregs of humanity and dragging them home".

Rachel said she did not want a baby "that much" anymore but said for years she "craved to have a baby". She changed her reply on reading the transcript and she said she did want to have a baby "very much" but she would "prefer to choose the right circumstances". She saw a third preg-

nancy as a "reprieve", that she had been forgiven and a way to prove that she was "a worthy mother". "Now was my chance to do it right; I was getting a second chance." When she miscarried she thought she was being punished. "I thought God would never forgive me: I'd never forgive me." She said she panicked even more after that and felt "now I'm never going to have a baby".

Rachel went for counselling after the miscarriage and says wanting a baby has got nothing to do with it. "I still wanted those babies." She says the craving, desperate urge to have a baby has subsided. "I still feel sad about three pregnancies that came to nothing. If I knew this would have happened I might have made other decisions then." This relates to what the doctor told Kim: that she might never have children and then regret her earlier decision.

Mary said she did not want children and was "too old". She loves children but if she tries to analyse it, "I think now I can't". Immediately after this she discloses her second abortion and my impression is that she is punishing herself by not having children: she now does not deserve to have children. She says when she thinks about her life she "can't believe the things I've done". Later she says she does not think it would be "fair" to have children. She says she "knows it is stupid" to think like that and that "the other two don't know the difference". Mary said she "has not convinced herself" that she would not be punished: that the child would be deformed or retarded. "I think I've just programmed myself into not wanting children and I really now don't want children because I don't want them but I think the whole initial reason behind it was that (the abortions)." Evidence of this can be found in her statement that "even though you live and cope with it there are certain things in certain ways that it has affected (her)" such as not having children.

There is a clear trend that the question of having children after an abortion becomes a major issue. While some are desperate for children, others feel they do not deserve them. There is also fear of being punished and being unable to have children. The tragic consequence is that many appear to deny themselves the fulfilment of their womenhood in this way even to the point of doing so in indirect ways for example by choosing inappropriate men. These responses indicate a level of ambivalence and lack of closure that would need to be explored in counselling.

n. What would you say to someone seeking an abortion?

I felt this question would reveal more about the respondents' feelings and what had or may have helped them and to further indicate what type of counselling is needed. To avoid repetition, answers that overlap with Sections h to j are not repeated.

Nadine said she would not advise anyone either way but would tell them what happened afterwards and with the psychologist.

Kim did not answer this but has subsequently provided a woman with the necessary information to seek an abortion.

Rachel and Mary said they would tell women to think carefully and consider if there were any viable alternatives. The woman needed to be "as informed as possible". Both referred to the finality of abortion - "there is no going back"; "you can't undo it". Mary said the decision has to be made immediately but she suggests taking at least two or three days. Rachel said it affected most people quite deeply but depended on the individual's conscience, values and circumstances. She had come a long way. She used to have dreams that she had a baby and forgot to feed it or left it somewhere or neglected and forgotten it.

Jill said she did not know because she felt every women had the right to choose but she knew how she had suffered. She would try to be supportive and she wished she could say she would share her experience but she would not because she would cry and that would not help. She also feared her secret would then be revealed to others. She would, however, try to say, this is how some women have felt. She said perhaps one day she would get to a point where she could tell. She had not told a friend who subsequently went through the trauma of an illegal abortion but had been as supportive as she could.

It appears that the respondents do not have a single approach to this but the majority would advise careful consideration of the options.

o. Would you have another abortion?

In the United Kingdom, repeat abortions account for 10 per cent of all terminations (Davies 1991: 200) and I was surprised that almost half of my sample (two out of five) had had second abortions.

Of those Rachel said she would not willingly have another abortion only perhaps in exceptional circumstances such as rape, while Mary said she "went cold" thinking about it. When she had a recent scare she panicked but her immediate reaction was "not to get rid of it" but rather she started thinking how it would affect what she was doing. She said, however, there was a part of her that might be callous and think "oh well, why not, so show me something I haven't done...I know there's a way out, no sweat at all." I believe the latter statement is evidence of this respondent punishing herself by being harshly judgemental. In similar vein, Jill says that having had an abortion, "what else am I capable of". Mary believes being self-critical has helped to keep her on an "even keel" because before the abortion "I was quite a big headed bitch".

Karen said she "did not think (she) could" because it had been "very harmful" to her and she had had to "learn how to feel again". Jill was the most vehement saying she would "rather die" and that she "would not cope emotionally or mentally" while Nadine was the only respondent who said she would because she felt it "had not affected (her) as badly as (she) thought it would". She said if her circumstances justified it she would but she recognised everyone was different and somebody else could be affected for the rest of their lives.

All but one of the respondents would not have another abortion and two identified the harm it had caused them. The theme is again evident in these two responses but it is difficult to predict actual responses especially in view of the seemingly high incidence of repeat abortions and considering that a second unexpected abortion is also likely to cause the woman to react with shock, horror and fear. Repeat abortion could also be a way of fulfilling the negative view the woman has of herself (in addition to her low self-esteem) and inflicting further punishment, so that, in the absence of intervention, it becomes a vicious cycle. The implications for counselling are therefore important.

4.3 CONCLUSION

This section has explored the main themes which have emerged from the interviews, how this relates to the literature, and the implications for counselling.

It is clear from the interviews that the decision to have an abortion has caused the respondents a great deal of pain and they have had various degrees of success in coming to terms with what was, in several cases, a hastily made decision. Some have recognised the need to mourn their loss while others have not but have found other ways to cope (through dreams). These findings illustrate the need for women to have access to support (especially in the absence of partner support) before and after an abortion and that while there are a host of possible patterns of reactions, these are also highly individualistic.

Counsellors need to be sensitive, flexible and attuned to the needs of their clients and thus must have a thorough understanding of any and all possible reactions to an unexpected pregnancy and abortion. Women need to be assisted to explore all their options realistically and if they want an abortion they must be informed about the procedure and what to expect. They need to know how they might feel afterwards so that they can allow themselves to feel sad. They also need to be counselled regarding contraception and why they became pregnant in order to avoid a repetition of their circumstances. They need to be aware that, especially in the absence of counselling, they may react years later and that responses may be triggered by the birth of another child. They need to know that the question of having children may become a major issue in their life. They also need to know that an abortion will affect their relationship - which may end - and future

relationships especially if they do not deal with the issues in counselling. If spiritual healing is assessed as being necessary and counsellors are unable to offer this service, women need to be referred.

Counsellors must be specially chosen for their understanding of the issues surrounding abortion or their willingness to be trained in this specialised area.

The next chapter will draw conclusions from these findings and make recommendations.

CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

This section will draw together the salient points from the preceding chapters and will focus on these to highlight the need for counselling.

At the outset it is important to re-state that my conclusions are based on the experiences of women who come from the more affluent sector of society and do not take into account women who have terminations for reasons of poverty. This is an area that needs further study as highlighted under 5.3 below. Also, the respondents are women who were willing to talk about their experiences and it does not account for those women who are silenced by the taboo and a possible inability or unwillingness to express their pain. The study also excludes women who have abortions for reasons of rape, incest, health risks or foetus abnormality.

The experiences of the respondents supports the findings of the emerging literature which calls for a recognition of the mixed feelings that accompany an abortion and which now see the need for mourning as in no way undermining the rights to choose a termination (Neustatter 1991: 110). The problem for South African women, however, is that the debate about abortion in this country is still focussed on of the issue of whether it is a right or not and I believe insufficient attention is being focussed on the need for counselling: the Act only provides for the promotion of the provision of counselling (The Choice of Termination of Pregnancy Act 92/1996: Sec 4). Furthermore, because the trauma of abortion is increased when it is obtained illegally, there is a great need in this country for service providers to reach out to the women who have been through this experience. Given the above, I am concerned that this may never happen.

This study has focussed on the negative aspects of women's coping in order to highlight the need for counselling but it does not suggest that all women react in this way and there is some evidence of positive outcomes and individual coping strengths which will be highlighted below.

It must be noted that there is overlap between the conclusions and recommendations and unnecessary repetition has been avoided.

This study indicates that the following are important:

- Pre- and post-abortion counselling are essential.

- Counselling must be non-directive and non-judgemental.

- Women's experiences of, and responses to abortion are highly individualistic. Personality characteristics and coping mechanisms as well as the circumstances and context of the experience and a host of other variables all play a major role.

- Women experience a mixture of feelings on discovering an unexpected pregnancy ranging from anger and guilt to excitement, confusion and panic (Davies 1991: 32; Haslam 1996: 39; Neustatter 1986: 16; Winn 1988: 11) but the main feelings are fear, shock and horror (Lane Commission in Neustatter 1986: 16).

- Abortion may be a life-changing decision (Davies 1991: 15-16) as described by Jill; it may have profound effects (Davies 1991: 15-16) - although some cope better than others - and may provoke a crisis (Davies 1991: 13; Neustatter 1986: 90) because the nub of the issue is the loss of a potential child. All the respondents allude to this if not directly.

- Counsellors must be equipped with knowledge of the grief process and be skilled in this area.

- Repeat abortions account for 10% of all terminations in the United Kingdom (Davies 1991: 200) and in my sample two out of five had two abortions.

- A high percentage of abortions could be avoided if women were aware of emergency contraception (Hall in Haslam 1996: 30) and had easy access to it. Education could be used to achieve this.

- There is a need to educate the medical profession on the harm they can and some do inflict by judgemental, thoughtless and callous treatment of women having abortions and pointing out that psychiatric damage can be avoided through sensitivity (Clarke et al. in Neustatter 1986: 94-95).

- A health issue which affects so many women and their families, should be made a priority. Sadly, the reality is that this is unlikely because of the limited resources other serious health challenges facing the country.

- Counselling needs to become de-stigmatised through education.

- All counselling should include questions about past pregnancies in the course of taking a detailed history.

- Women may interact with counsellors or helping professionals at any stage of the process: before or decades later.

- It is possible that women's reactions may be delayed for many years after the abortion (Blacker

1995: 48, 59; Neustatter 1986: 108; Sutton 1995: 59; Winn 1988: 7, 99) and that unexpressed feelings may remain an undercurrent in their lives until they are understood and resolved (Davies 1991: 16).

- Abortion needs to be de-politicised because it leads to women being assisted to have terminations without the decision being properly thought through. In an attempt to counteract the pro-life lobby, the pro-choice movement support the women but there is a failure to render objective counselling.

Pre-abortion counselling

- The development of trust, warmth, empathy and acceptance are essential in pre- and post-abortion counselling as are confidentiality and the establishment of a contract.

- Unexpected pregnancies may cause fear of parental disappointment and shame among younger women.

- The length of counselling will depend on the individual but there is always an urgency for the woman to make up her mind because it is better to have a first trimester pregnancy as this is less traumatic than later on (Neustatter 1986: 54). Decision-making, however, must not be overly hasty because abortion "cannot be undone" (Winn 1988: 50); women need to under stand this finality.

- Pre-abortion counselling should comprise a realistic examination of the three options and the decision must not be made too "easy" (Winn 1988: 48).

- Does the woman have a value system that will allow her to be comfortable with her decision (Neustatter 1986: 52).

- Sensitivity to her feelings is paramount and the choice of words she uses will provide insights. Referring to a foetus when she talks about the baby will signal that you do not understand and are minimising the crisis (www.gynpages.com/cws/1/html).

- Some women would like to talk to others who have had abortions before and after.

- Relationships may change and often end after an abortion (Davies 1991: 50).

- Myths abound and thus concerns about the safety of abortion need to be outlined (Neustatter 1986: 53).

- Women need to understand why they became pregnant in order to avoid a repetition of events.

- The timing of the provision of contraception information is important because women can feel blamed if it is assumed she failed to take precautions.

Post-abortion counselling

- Counsellors need to be aware that women use denial (Koop in Dillon 1990: 9; Rue 1995: 22) and repression (Saltenberger in Dillon 1990: 13) in order to cope.

- Women often present for counselling for reasons other than a past abortion as Jill did and this may emerge as the source of their problems (Dillon 1990: 13, 43).

- It is essential to develop a "deep trust" relationship (Kent in Dillon 1990: 3) for details of a past abortion to emerge.

- The question of having children later may become a complex issue as it did with Jill, Mary, Kim and Rachel.

- Women expect to be punished by being unable to have children (Davies 1991: 160) or expect their children to be damaged (Winn 1988: 53).

- Some have an inability to pray (Casey 1995: 80); some seek out assistance from the church; some need to atone (Kim "paid (her) dues" through work; Jill sponsored a child).

- Some women display "symptoms" described as evidence of PAS such as trigger events (Dillon 1990: 20-25), anniversary reactions (Dillon 1990: 26-29), relationship problems, low self-esteem in the form of feelings of worthlessness.

5.2 RECOMMENDATIONS

It follows from this and from the interviews themselves that:

- counselling should be mandatory even if it is only a half an hour before - to establish whether the woman has made a reasoned decision (Haslam 1996: 58-59) - and after and especially in the case of minors.

- Services should be provided at a neutral and discreet venue, where a woman's privacy and the fact that she has had, or intends having an abortion, is not apparent simply because of her presence there. The ideal would be well-women clinics where the focus would be on women's health issues. The reality is South Africa is that because of scarce resources, facilities which

are supposed to offer the service have not yet done so (Mail and Guardian 7-13 February 1997: page unknown) and it is unlikely specialised clinics will be provided unless the private sector steps in.

- lists of counsellors should also be made widely available so that women do not have to go through the humiliation of hunting for help.

- counselling should be conducted by people who are specifically trained for the purpose. Trained lay counsellors as suggested by the SANCCFW (1997: 4) are acceptable in the context of South Africa's limited resources. I do not believe, as has been decided in South Africa, that the task should fall mainly with health care providers for reasons already stated unless this will be their only task. The reality of scarce resources does not bode well for adequate government-funded service rendering.

- All mental health service providers, ie. social workers, psychologists and doctors, should be sensitised to the complex needs of women who seek and have terminations as part of their training curriculum as is planned for the nursing profession (SANCCFW 1997: 2).

- A minimum of a 30 minute interview should be held to assess the woman's decision and to screen for the risk factors which may affect her coping. This should not be in the context of trying to convince the doctor that she needs it but by a professional to assess whether she has fully explored all her options. Ideally counselling should be available as long as the woman requires it.

- Counselling should be flexible and tailored to meet the needs of individual women at whatever stage they are at in the process - be it before or decades after - and counsellors should be aware of those at greater risk of experiencing problems coping (Adler et al. 1992: 1200-1201; Casey 1995: 74; Dillon 1990: 31-32; Major et al. 1985: 585; Neustatter 1986: 94).

- An adherence to the client's agenda is important in both pre- and post-abortion counselling but this must be flexible. Nadine was angry when she wanted to be taught coping skills and instead had to look at her relationship with her father. On the other hand Jill did not want to discuss her abortion and resented her therapist raising it but was ultimately thankful she did. These examples illustrate the level of sensitivity and attunement to the women's needs that are required incounselling.

- Once the woman has made up her mind, the waiting period to obtain an abortion should be as short as possible.

- Information about contraception and emergency contraception and the provision of this should be extensive.

- Counselling and support should also be available to men.

- The challenge to meet the needs of women who have undergone illegal abortions should be taken up by interested groups. This is a difficult problem to address because of the associated secrecy and is evident in the respondents abstract talk of the need for counselling but their own lack of desire to seek the same. The need for education aimed at bringing about understanding of women's complex feelings thus needs to be addressed in tandem because public empathy may serve to undermine the taboo. The development of guilt has been found to depend on prevailing societal attitudes (Ashton in Neustatter 1986: 94).

Pre-abortion counselling

- The first task in pre-abortion counselling is to establish whether or not a pregnancy test has been taken. If not, this is the first step.

- The counsellor needs to assist the woman through the shock, horror and fear (Lane Commission in Neustatter 1986: 16) of the discovery of the pregnancy.

- The next task is to establish who she has told, who she wants to tell, does she need a mediator and what her feelings and those of the father are and whether or not she can expect support from him. Parents often provide support (Neustatter 1986: 45) so this resource must not be excluded.

- Parental disappointment is a natural response and the counsellor needs to help both parties understand this.

- If support systems - both practical and emotional - are lacking this needs to be assessed in order for alternatives to be put in place both before and after.

- The counsellor should assist the woman to explore her options realistically by thoroughly weighing up the pros and cons of each. The counsellor needs to slow the process down to ensure the decision is fully informed (Doherty 1995: 9) because it has been found that coping is assisted when the decision has been properly considered (Neustatter 1986: 94). The goal is for the woman to thoroughly explore what will be best for her.

- If the woman wants an abortion, why does she want it, what does the father say, is it to save the relationship.

- If she chooses an abortion, how does she think she might feel afterwards, explain some of the possible reactions both positive (relief, personal growth) and negative (low self-esteem, feelings of worthlessness and of being flawed, regret) and give permission to her to have these feelings (Winn 1988: 47, 117). She needs to know that grieving is part of the process (Neustatter 1986: 105).

- The woman must be aware that depression afterwards may also be linked to post-partum depression which is a result of normal hormonal fluctuations and she may need treatment for this (SANCCFW 1997: 1-2).

- While waiting for an abortion women need to be instructed in practicalities and encouraged to treat morning sickness, rest and look after themselves.

- Women need to be told about the procedure so that they know what to expect but these should be tailored to the needs of the individual. In South Africa the procedure is generally performed while the patient is awake which can be traumatic as Jill found.

Post-abortion counselling

- The length of post-abortions services depends on individual needs and thus flexibility is essential.

- Counsellors must examine how they can assist the woman to cope with her mixed feelings of sadness, loss and a need to mourn, which they may be unable to identify. The mourning may be about the loss of a potential child or the loss of childhood (Davies 1991: 146-148).

- Counsellors will need to help women to integrate the experience into their lives and while there will possibly always be sadness and women may not forget, they can also grow (Davies 1991: cover) from the experience in terms of self-insight and confidence.

- Ambivalence, for example, regarding whether she wants children or not, may indicate a lack of integration of the experience and this will need to be addressed.

- The goal should be to help the woman live with her decision rather than persuading her it was the right thing to do (Casey 1995: 74-75).

- It is evident that women have different needs and what may work for one may not work for all thus assessment is important as is a comprehensive overview of what may help the individual.

Some women have been helped by the following: dreams, nurturing a dog, reading about women's experiences, writing a letter to the unborn child or God, and the use of imagery (www.gynpages.com/cws/1.html).

For others, a ritual to say goodbye, such as a church service, naming the child or holding the foetus depending on the length of gestation, may be useful. Nadine found seeing the foetus on a scan had a calming effect. While some might find these methods bizarre, they have helped some women. Support groups are also important because it helps remove women's feeling of isolation and will help them realise they are not alone in their feelings.

- Counsellors must help women identify their positive coping strengths and assist them to identify any personal growth as well as identify progress in achieving resolution and closure.

- Counsellors need to be aware of sympathetic religious resources in their area where a woman struggling with this aspect can be referred for spiritual healing.

5.3 SUGGESTIONS FOR FURTHER RESEARCH

Further study should investigate women's coping with the choice of abortion where the decision is based on survival. In a country such as South Africa where there is a high rate of poverty, unemployment, female subjugation in the form of men refusing to allow contraception or use condoms, the effects in terms of coping need to be examined. Halkett (1997) said in her discussions with Baragwanath Hospital, she was told women presenting there for abortions were not at all ambivalent about their decision. It could be that, because of the above reasons and the fact that impoverished women have a daily fight for survival, this takes precedence over feelings of loss or alternatively, that in order to cope, these feelings are buried. People who face survival issues cannot afford to examine their feelings too closely and so use denial and repression. The issue of being sure about a decision to terminate having less negative consequences as highlighted earlier in the literature would also be a factor here (Adler et al. 1992: 1200-1201).

I also believe a study of the long term effects on women's relationships in general should be explored. Difficulties with relationships are given as a "symptom" of PAS (Dillon 1990: 20-25) and although this study did not set out to explore this aspect, I am aware that at least three of the respondents have had unstable relationships over a long term. Mary, notably, commented that she always found the "dregs of humanity" and wondered if she was subconsciously punishing herself.

There is a need for methodologically sound and unbiased long term studies on the impact of abortion on women as these are problems that have been identified (Adler 1979, Dagg 1991,

Illsley & Hall 1976, Simon & Senturia 1966 in Adler et al. 1992: 1197). I believe this applies to men as well. While some of the non-positivist literature incorporates chapters on the effects on men, the focus - correctly - is on women as they bear the physical and emotional brunt of termination. This must not be at the expense of studies about women but there is a need for greater focus considering, for example, the manifestation of Rachel's boyfriend who became physically abusive.

There is also a great need for women to begin speaking out about their experiences so that some of the secrecy surrounding abortion is removed as this in turn will assist them in coping. Thus, researchers and writers, need to provide the platform for women to speak out - through further research which provides women with a voice and the publicising of women's stories.

APPENDICES

APPENDIX 1

1. Methods used to terminate a pregnancy

Haslam (1996: 107) says the method used to terminate a pregnancy depends largely on how far it has developed.

A lengthy explanation of the procedures used in England follows and while much of the detail may be unneccesary for the client, it is important that counsellors are aware of the information should they be asked. The information may provide insights for South African counsellors and be useful for women who intend seeking abortions overseas or who had the procedure there.

(a) Medical termination

Haslam (1996: 110) notes that early medical termination avoids cutting, anaesthetics and other problems potentially associated with surgery. The drug used is known as Mifegyne, Mifepristone or RU486, which is used in combination with prostaglandin. He says Mifepristone is a steroid hormone which works by blocking the production of progesterone. During pregnancy circulating progesterone stops the uterus from contracting. The steroid therefore encourages the uterus to contract and prevents the placenta from developing fully. Without the latter, the developing foetus cannot be sustained. The use of prostaglandin, which occurs naturally in the body and which is normally released from the lining of the womb during a period, stimulates contractions of the uterus and also leads to softening and opening up of the cervix. The combination of these drugs therefore leads to the foetus being expelled as if by miscarriage (1996:110-111). In South Africa the drug used is Misoprostol (SANCCFW 1997: page not numbered).

The advantages are that it can be used very early, usually does not require an operation and may allow the woman to feel more in control and regard it as more natural than surgery. The disadvantages are that pain and bleeding can be quite significant, and one per cent of women will require emergency blood transfusion and/or an operation and in four or five per cent the miscarriage will not be complete and require an operation after all. It also requires three attendances at the hospital or clinic, and is a more drawn-out procedure (Haslam 1996: 110).

The drug can be used up to 63 days from the first day of the last menstrual period (nine weeks or less). Haslam says women needs to understand the method as well as the alternatives available. If the drug does not work there is a potential risk of it causing major damage to a developing foetus and for this reason surgical termination would then be recommended (1996: 111-112).

The woman will be given a scan to check that the pregnancy is early enough and a blood test to check the blood group. She will then be given the Mifepristone which is usually in the form of two large tablets on an outpatient procedure. It is important to stay in the clinic for at least two hours in case vomiting occurs and an appointment is given for 36 to 48 hours later so that the prostaglandin can be given.

One in 10 women will start to bleed within 24 hours but by 48 hours, 60 per cent will be bleeding and this is associated with crampy pains similar to period pains. Nine per cent of women will need hospitalisation because the bleeding is heavy and some three per cent will abort before the prostaglandin is given. Paracetamol or a codeine-based drug can be taken for pain. Aspirin, ibuprofen and Ponstan should not be taken (Haslam 1996: 113).

The prostaglandin (usually gemeprost) is given after 48 hours and the patient will almost always be admitted. It is typically given as a vaginal pessary although an alternative orally-active tablet known as Misoprostol (Cytotec) may also be given. The woman will need to remain under observation for six to

eight hours. For those who are not bleeding already it will usually begin after a couple of hours and is likely to be similar to a normal period for a couple of days gradually getting less and less. On average women given RU486 will bleed for a further 12 days and one in 100 will need to be hospitalised. In most women the termination will have happened by the end of six hours in hospital. The treatment is completely effective in about 95 per cent of cases. Five per cent may require antibiotics for possible infection. If the oral contraceptive is to be used after termination, the first pill should be taken on the day the prostaglandin is given (Haslam 1996: 114-115).

Haslam (1996: 116) says that if the availability of medical termination means that a woman rushes into using the method before she has really had a chance to think everything through, then is could cause longer term psychological harm. He says because something is technically easy does not make it automatically psychologically easy.

(b) Surgical methods

These require an anaesthetic and a brief admission to hospital. The techniques available depend on how far through the pregnancy the woman has gone.

Very early. Menstrual aspirations are performed within a week of the missed period.
Up to 13 weeks: vacuum termination (or rarely D&E - dilation and evacuation).
14-20 weeks: D&E or prostaglandin termination.
Over 20 weeks (exceptional circumstances only): medical induction with prostaglandin which means going through labour and giving birth (Haslam 1996: 116-117).

Menstrual aspiration: no general anaesthetic is required and sometimes not even a local will be needed. A sterile, narrow, flexible cannula (or tube) is inserted through the neck of the womb. The other end of the tube is attached to a vacuum source - sometimes simply a large syringe. The uterus is then emptied by suction, providing a method that is effective and safe (Haslam 1996: 118).

Vacuum termination (VTOP): is the most common technique and requires an admission to hospital as a day patient. Initially a prostaglandin pessary may be given to help relax and open up the neck of the womb. Usually a light anaesthetic is given or a local may be offered.

Once asleep the surgeon will swab the vulval area with disinfectant and will insert a speculum to hold the walls of the vagina open. A special type of forceps, known as a tenaculum, is used to clip onto and steady the cervix and a series of dilators are used to open the canal in the cervix. The amount the cervix is dilated depends on how far through the pregnancy is. The less the cervix is stretched the better because over-stretching can lead to cervical incompetence, which can be an occasional after effect of termination.

This means the os (or small canal inside the cervix that leads into the uterus) becomes damaged and can no longer stay closed under pressure. This carries the risk that future pregnancies may miscarry at about four or five months. Miscarriages that occur earlier are very rarely due to cervical incompetence.

A sterile plastic tube is inserted through the cervix and the suction procedure described above is carried out. The surgeon will then scrape out the womb using a sterile metal instrument called a curette. This is done to make as certain as possible that the termination is complete. The procedure takes no more than 15 minutes and the patient will slowly wake up (Haslam 1996: 118-119).

If the woman has a local anaesthetic she will go into the theatre and her feet will be placed in stirrups. She will have a vaginal examination and local anaesthetic will be injected into her cervix. Once this has

taken effect the operation will be carried out. She should feel no pain though many women are aware of a dragging sensation in the lower abdomen. Manipulation and stretching of the cervix can sometimes cause a woman to faint or feel sick. There is also some noise from the suction machine which might be distressing. After the operation many women have some crampy lower abdominal pain, similar to period pain, some feel sick and may vomit. This soon passes and bleeding typically lasts for four or five days and may get a slightly heavier before stopping. A few women bleed slightly for up to a month (Haslam 1996: 119-120).

• Rhesus incompatibility

Haslam (1996: 160) says a woman will need an injection if her blood is Rhesus negative and the foetus is Rhesus positive as she could develop antibodies which can seriously damage future pregnancies. It can be completely prevented by an injection of anti-D gamma globulin as long as this is given within 72 hours of the termination. If the woman is Rhesus negative she should be given the injection before she goes home. If she is Rhesus positive there is no need. If she is in any doubt, either about what blood group she is, or whether the injection was given, she should ask.

2. Possible complications

The following are some of the possible complications that can arise as a result of a termination.

(a) Cervical incompetence

Cervical incompetence described earlier is of no importance until the woman becomes pregnant again. If the os is significantly damaged, when she is pregnant the weight of the growing foetus presses down onto the os and gradually stretches it open.

The risk of the cervix being damaged is greater the later the termination. One or two early terminations only carry a very small risk but someone who has had three or more may well be at an increased risk of later cervical incompetence. If the condition is diagnosed, which often does not happen until after at least one miscarriage, then some gynaecologists will insert a stitch, the Shirodkar suture, into the cervix early in a subsequent pregnancy to keep it tightly closed. Whilst the method has been used for many years, there is now some debate as to how effective it really is (Haslam 1996: 181-182).

(b) Stenosis of the cervical os

This is the opposite of the above. If the os becomes stenosed it means the dilation procedure results in it becoming thickened and scarred and as a result it does not open as freely as before. Menstrual blood cannot flow as freely and this has been linked to increased period pain. This can be relieved by gentle dilation of the cervix (Haslam 1996: 182).

(c) Haemorrhage

Haemorrhage is very rare and if it occurs it tends to happen almost straight away. It can be caused by some of the amniotic fluid surrounding the foetus passing into the woman's blood stream. It can affect the way the blood clots and lead to very heavy bleeding (Haslam 1996: 181).

(d) Perforation of the uterus

This is a small risk of any D&C. The curette can damage the uterus wall and even make a small hole. It would cause immediate heavy bleeding at the time of the operation and the surgeon would deal with it (Haslam 1996: 182).

• Referring to illegal abortions, Haslam (1996: 184) says complications arising from these can be very serious and dangerous. In the long term infection can lead to scarring of the Fallopian tubes, which can easily lead to long-term infertility.

3. Applying and waiting

Haslam (1996: 130-133) notes that the deciding and waiting period is difficult because there is anxiety about the length of the waiting period (the foetus is growing), what will happen in hospital, concerns about hospital treatment - whether staff will be kind and what tests will be carried out. He says the time needs to be used constructively to work out why a termination is being sought - for herself and so that when she is seen she can explain her views clearly and calmly. Some people make notes.

Questions to ask the referring doctor and the second who signs is when will the operation be performed, what method will be used and can you take a friend or partner with.

Haslam (1996: 138) says during the waiting period the woman needs to look after herself as there is evidence that she will benefit. Getting some exercise, eating healthily, even pampering herself can all help. This is also necessary because the woman may feel that, because of what she is planning to do, she is not worthy of being taken care of.

Haslam (1996: 139) says some women find it helps to write down their feelings and emotions and suggests keeping a simple diary. He says one woman told him she wrote letters to a close friend but never sent them. Keeping constantly busy rarely helps - he says the woman needs to look after herself, not punish herself. It is also useful to use the waiting time to consider why the pregnancy occurred and exactly what her reasons are for seeking a termination. He says being absolutely clear about her reasons, attitudes and beliefs can make a big difference and she will spend less time agonising over whether she made the right decision (Haslam 1996: 141).

(a) Relaxation techniques

Haslam (1996: 134) suggests learning relaxation techniques to deal with the stressful waiting period otherwise there can be serious consequences such as severe anxiety, sleeping difficulties, loss of appetite, poor self-esteem, difficulty in decision-making, irritability and poor concentration. Other signs of stress are nail-biting, teeth grinding, excessive sweating, twisting hair continually and itchy, sore irritating skin rashes. Feeling tense can lead to physical side effects such as a racing heart, the mouth going dry, tense muscles, legs feeling like jelly and a constant need to go to the toilet.

Haslam (1996: 134-136) says the woman may feel this time of her life is simply too stressed to learn relaxation but says there needs to be some positive outcomes from what may be an overwhelmingly negative experience.

The counsellor can suggest techniques to help with coping so it is important for the counsellor to be knowledgeable in this area. Haslam suggests the following method: wear loose clothing and lie flat on your back, imagine that you are somewhere pleasant, in the sunshine, in a country field, by the sea, even simply in bed. Start by screwing up your facial muscles as tightly as you can and then let them relax. Work through all the face muscles in turn: frowning to tense the forehead and then relaxing; screwing up the eyes and then relaxing; clenching the jaw and then letting it fall loose.

When you have relaxed the face, lift up your head and let it fall back gently. Next relax your shoulders. Start by pressing them down and then let them go loose. The arms and fingers are next, and the technique is similar. Hold them out to one side, and make them as taut as you can, and then relax them completely. Finally, lift each leg into the air for 30 seconds, making the muscles as tight as you can, then let them go limp and drop back.

When you are practising, relax the legs, arms, neck, forehead, eyes and jawbone one after the other for about 10 minutes. Then lie still and relax for a little while, enjoying the feeling of loosened muscles (Haslam 1996: 134-136).

Haslam (1996: 136) says laboratory studies have shown that a spell of concentrated relaxation like this can be more beneficial than a standard dose of a tranquillizing drug like Valium, but with no side-effects. The woman will soon be able to use this form of relaxation at a few moments notice and will be able to get control of her stress rapidly and safely.

Other stress relief possibilities include slow deep breathing techniques. Ways to assist relaxation are: exercising before you relax, having a warm bath before, choosing a regular routine time, yoga or meditation and, he says, do not forget the simple things like music, books and television. If you have a pet, remember that scientific tests have shown that levels of stress symptoms and even blood pressure have been shown to fall significantly when people cuddle up to their pets (Haslam 1996: 137).

4. Practical preparation for the termination

Haslam (1996: 147) says arrangements have to be made for time off work (normally two days); as well as all that will be needed for a day in hospital including toiletries, normal medication, sanitary protection and reading material. The hospital will also need clear guidelines on who can be told but normally will not give out any information without permission.

Haslam (1996: 149) says the woman must not eat or drink for at least eight hours before the operation. At check in basic information will be taken and a payment may be necessary. If the necessary medical checks have not been performed in the out-patient clinic, there might be a urine test, blood test for blood grouping, possibly an internal examination and she will almost certainly be weighed (or asked her weight). This last information is used by the anaesthetist. She should find out about visitors beforehand and if necessary make arrangements for this to be allowed.

The woman will need to make arrangements to be fetched and it is preferable that she is not alone the first night after the operation. Most people need emotional support, and it can make a big difference if she is not left alone with her thoughts and her fears. Some units will not let her home if this arrangement is not made (Haslam 1996: 160).

If the client has never been to hospital she can be prepared for what to expect in terms of surgical preparation: that for the anaesthetic she will be given a pre-medication injection to make her feel sleepy before going into theatre and that when she wakes up from the anaesthetic she may feel drowsy, nauseous and dizzy and she may have cramps (Haslam 1996: 151).

5. After the operation

Haslam (1996: 162) says if the woman passes large clots of blood on several occasions, over a couple of days or more, this means that the bleeding is continuing more than is ideal and she should seek advice. Very occasionally a tiny piece of membrane or other tissue may be left behind and can cause increased bleeding and make her more at risk of developing infection. If this is the case she may need a D&C (scrape) operation.

The woman should also contact the doctor if she has any of the following symptoms:

- bleeding that is heavier than a normal period;
- bleeding that is bright red in colour, rather than dark or brown;
- a smelly offensive vaginal discharge;
- symptoms of shivering, sweating or aching all over;
- a raised termperature;
- sickness persisting more than two weeks after termination; and
- a sudden heavy loss of blood (Haslam 1996: 163).

He says most hospitals and clinics will provide an advice sheet. These are the usual the woman should follow:

- she must use sanitary towels instead of tampons until her check up;
- she can bath as soon as she feels well enough but must not use bubble bath or oils until vaginal bleeding has completely stopped;
- she must not have vaginal sexual intercourse for two weeks after a medical termination, or intercourse without using a condom for six weeks after a surgical abortion;
- avoid manual stimulation inside the vagina for about three or four weeks after the termination;
- avoid strenuous activity such as sport and lifting heavy weights for at least a couple of weeks;
- some breast discomfort may occur but this should disappear completely after two weeks, if not she must see her doctor;
- her period should start four to eight weeks after the termination and if there is any change, such as passing blood clots or more pain than usual, she should see her doctor (Haslam 1996: 165).

The woman should have a check up three or four weeks after the operation. If she had a medical termination she will almost certainly be offered an appointment about seven to 10 days after the second treatment. The main purpose of this is to ensure the treatment has been effective. If it has not succeeded there is a very real risk that the foetus could have been damaged (Haslam 1996:167).

Haslam (1996: 167) says the visit can also check for any post-operative infection that may have developed and be an opportunity to talk about feelings and arrange for any further counselling that may be needed.

APPENDIX 2

CASE HISTORY 1: JILL

Jill is 37 and has a son of 3. She discovered she was pregnant when she arrived home from a year's working holiday in England. She went to a neighbouring state for the abortion because it was illegal in South Africa at the time. She is the only respondent who cried during the interview.

a. How long ago did you have the abortion and how old were you at the time?

It was 15 years ago and I was 22.

b. The nature of your relationship at the time.

I met my boyfriend while overseas. I was living in London and it was my first serious relationship. We had been going out for three months when I fell pregnant. I had just arrived back home and he had been sent to Germany with his company. When I knew we were going to have a sexual relationship I phoned a family planning clinic but for some reason was told they did not supply pills. I was young and naive and it was a classic case of I never thought it would happen to me. We had spoken about it and he said if I did fall pregnant he would stand by me. We really were so stupid. I was 22 and he 19.

c. Your feelings and those of your partner when the pregnancy was discovered.

I felt terrified and was in a state of shock. I was doing a job I hated and having dizzy spells as a result of being pregnant. All I wanted to do was get back overseas to sort it out there but I had no money. I did not want to tell my parents but eventually I told my mom and she was supportive. She told me a close relative had had an abortion years ago. It was funny how I remembered immediately the time, I must have been about 12.

I telephoned my boyfriend and he was shocked. It was expensive and difficult talking on the phone so I waited anxiously for him to write. His letter seemed to take forever. My feeling was that if we did not get married I would have an abortion. I wouldn't allow myself to think of this as a baby until I knew that. I probably knew instinctively that that was a way of protecting myself. I remember my family talking about us getting married by proxy. My heart sank when he wrote saying he was not ready to get married. I remember my mom bringing the letter to me at work. He said he had seen too many enforced marriages go sour but he also said I mustn't have an abortion. He was Catholic and it was against his religious beliefs. Because of that I didn't tell him. I lied and said my period was late.

d. Making the decision.

I didn't really consider all my options. I was in such a state of denial. Once I knew he didn't want to get married, the pregnancy was something that just had to be ended. I could not acknowledge that I was pregnant. I couldn't face it alone. Before telling my parents I remember, like yesterday, lying on my bed and feeling terrified. I felt so ashamed that I had gone overseas for a year and come back alone and pregnant. I just wanted to get it over with and go back overseas. I saw it as the only way to save the relationship. If I had had the baby I would not have been able to go back overseas. Adoption wasn't an option, it was the shame of being pregnant and alone. I couldn't give a baby away anyway. I didn't tell him because I was scared he would end it for that reason. How I thought I could actually maintain that relationship knowing what I did and not telling him, I don't know. I really wasn't thinking very clearly.

e. Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?

I was told the suction method would be used but had no idea what to expect. I don't remember worrying about it. I just knew my relative had had a backstreet abortion and I was not going to have that and that

was enough to make me feel better. I was not told how I might feel and I'm not sure if it would have made a difference, I blocked how I might feel and had this sense of well, I'll just have to live with it and deal with it afterwards.

f. The abortion itself.

It was difficult to find someone who would carry out the abortion. I went to Pretoria where I saw a doctor who told me very off-handedly like I was a stupid child and after a rough examination that he didn't even think I was pregnant. This was after the pregnancy had been confirmed by my own doctor. My mother fainted when the doctor confirmed it. It felt very unreal. He told me to come the following day for a D&C and said there was a possibility I could die. It was an extremely traumatic experience. I was treated without any respect or dignity, like dirt. I left his surgery sobbing.

After that my mom made many calls through various people and we heard about a doctor in Lesotho. My parents took me. We were scared we would be turned away at the Border as it was rumoured there were many South Africans going there for abortions.

When we arrived at the hospital the doctor had gone off duty but someone went to call him. It was Easter Monday and it was my grandmother's birthday. I always remember the date. My baby would have been born in October but I'm vague about dates. My child would be the same age as Prince William, it's strange to think I would have a child that age. I can't remember if I was seven or nine weeks, I like to think it was seven because the baby is not fully formed whereas I now know by nine weeks, the baby even has a brain. I sometimes sit down to work it out but I let my mind go vague.

My mother spoke to the doctor and came to call me. I was in the car with my dad. The doctor said I must hurry as he wanted to go. He had boasted to my mother that he did the most abortions in Africa. I sat in the car feeling uncertain and unable to make up my mind but the pressure from the doctor was enough to make me go. It felt as if it was done almost unthinkingly. At that moment I was scared and unsure.

The doctor was Dutch and what sticks out in my memory was how afterwards he told me to go and lose weight and get a tan. I was awake and the procedure was quick. I can still remember the suction sound and at the time remembered thinking I would remember it all my life. I remember saying "Oh, God, Oh God," throughout. I remember the operating theatre being very large with windows. When it was over I walked through a kind of kitchen area where I believe the staff were washing the foetus down the sink. I felt dazed. The memory is a very painful one and I blocked it for years. I think it is only recently that I have remembered that. Putting it into words though, which I couldn't for a long time, has made it a less horrifying memory. They then hurried me out. I went back to my mother and the doctor gave me a lot of tablets to take immediately.

When I went for a check up at the gynaecologist some weeks later, I had a slight infection. The doctor also cauterised me although I didn't understand what it was for but now I wonder if something wasn't left behind. The doctor was old and kind but said he hoped I wouldn't use this as a contraceptive method again. I felt hurt and angry by that, like my stupidity was being rubbed in, but I was grateful for his kindness.

Years later when I had another gynaecological problem, a gynaecologist told me callously that I might not be able to have children as a result of the abortion and when I cried, asked me what I was crying about as he was not sure yet. As it turned out, there was nothing seriously wrong. It seemed like he was deliberately trying to hurt and upset me for what I had done. I felt furious with him for a long time.

I never withhold the information from doctors but hate it as it has made me sometimes feel judged. I also hate the fact it is on my medical records for receptionists to see. I have never had the courage to ask to have the information removed.

g. Your feelings afterwards, immediately; several years later; after having children.

On the way home in the car, it was about a seven hour journey, I remember lying on the back seat of the car crying over what I had done. I was also scared that I might haemorrhage and die in the middle of nowhere.

We had to stay in a hotel on the way home as it was a long trip. I ate ravenously and felt ashamed for doing so. It was like filling a void in me. I was wearing my favourite dress but after that I could never wear it again.

Soon after this I went back overseas and the relationship fizzled out. My boyfriend seemed to believe I had tried to trap him into marriage. I never told him, I just said my period had come late.

I remember walking down the street one day feeling absolutely worthless, it was the first time I had ever thought of suicide, not in a serious way, but I just felt so worthless that I did not care if I died there and then. My life no longer had meaning after what I had done. The abortion coloured my whole life and changed it forever. I could never think well of myself again because I had committed such a huge sin, there was a permanent flaw in me and it was always in the back of my mind. It was a case of don't think too much of yourself, just remember what you've done. But over the years I have come more to terms with it but it is still there, a part of me and it always will be. There is no turning back the clock.

I went into another short-lived relationship which was disastrous because I was completely numb. I did a lot of crying and could not feel anything emotionally for my new boyfriend. I was just numb.

It was only after I had my son that the real enormity of what I had done hit me. It was only then that I experienced the loss. Before that I had felt a terrible sadness but had never regretted it and had seen it as my only option at the time. When my son was born the reality that I would never know my unborn child hit me. It was only then that I began to mourn. To this day I am still unable to talk about it with my family although I want to because I know my mother must also have suffered.

Thirteen years after the abortion I wrote to the father who had since married and had children. I wanted to ask his forgiveness because I felt if he could forgive me, I could begin to forgive myself. Before that I once phoned Lifeline but a counsellor told me I had survived and asked if it would be fair to disrupt his life so I left it. My boyfriend said he had always wondered and felt guilty about it now but I never blamed him because he had been so young at the time. I had misunderstood and presumed that because he did not want to get married, he was dumping me. He said that had not been the case. He feels guilty about it and responsible but he does not like to talk about it. When I was thinking of telling him, I gave a friend the letter to read to ask her if she thought I should send it. After meeting him when I went overseas on holiday and I saw how unhappy he was I had decided I wasn't going to tell him and then he wrote and raised the issue and that was when I asked my friend what she thought.

In the past if anything came on TV about abortion while I was watching with my parents I became very uncomfortable. I could hardly breathe and would sit like stone. It's not as bad as that anymore and I tend to put on a kind of intellectualised front about it and comment on it from a political viewpoint.

I tried to make amends, atone, call it whatever, by sponsoring a child through World Vision for a few years afterwards but then my financial circumstances changed and I could not afford it.

h. Did you have any type of counselling before or afterwards?

No, but later that year when I was back in England and went to a clinic for contraceptive pills I was offered counselling but felt so raw and tearful, I said no. In actual fact, I had wanted them to say I must but they did not push it.

i. What was useful, what was not?

Last year my psychologist would bring up the abortion even when I didn't want to and even though I did not want to focus on it, I was glad she pressed the issue. I cried a lot in therapy and I think that helped. I didn't go to her about the abortion but it came out and she said it seemed that I had never mourned the loss.

j. What would have helped?

I wish someone had sat me down and made me acknowledge the pregnancy and realistically consider all my options and challenge me about having a baby. It may not have changed my mind but at least the decision would have been more reasoned. The best person would have been someone neutral and unbiased.

It would have helped to have someone to talk to afterwards, a neutral person. I never speak about it to my family, we have never discussed it. I wish the staff at the clinic had been more forceful in encouraging me to talk then because I would have liked to. It was only 13 years later that I finally confronted it in therapy because I would cry alone at odd times after the birth of my child. I had my son out of wedlock due to the nature of my relationship at the time but mainly because I was becoming more and more scared, probably irrationally, that I wouldn't be able to have children.

k. Who else knew/did you talk to?

Only my parents, brother and aunt knew. My mother had also told her boss at the time because she sought his advice and the family doctor. To this day I hate the fact that my mom's boss knows that about me. I hate people judging me and making assumptions about me. My brother was the only one who said I should have the baby but that was all. I never told my friends, I was too ashamed. I sometimes think of telling close friends because I think they should know something that important about me. My fiancé also knows. We went through a rocky time once and were going to break up and I told him because I thought he should know the worst about me. He has not been that supportive because when he's angry he says that's why I am like I am, whatever that means. He knows how much pain it has caused me but it is not something we talk about.

A friend of mine once had an illegal abortion and despite her pain, I could not share my experience with her because of my fear she would tell other people. I supported her but to a certain extent I feel bad that I couldn't be there for her in that way but I weigh this up against my need for no-one to know and she might have told people.

For a while I tried almost to justify it. I had a very close old friend who was a nurse and I used to question her about having a miscarriage as a result of a uterus which lies back like mine does. I hoped she would say yes, there's a strong possibility but she used to try and reassure me that I wouldn't. She didn't know I was trying to let myself off the hook for what I had done and so allow myself to say well, I would have lost the baby anyway. I just imagined the fact that my uterus lies back would have an effect, it doesn't. I was grabbing at straws to make me feel less guilty.

l. Did you have any religious or moral views on abortion before the termination or after and did these change?

As a teenager I had been completely opposed to abortion and had even kept magazine clippings about abortion yet it was the first thing I thought of when I discovered the pregnancy.

After the abortion I felt passionately that women had a right to make the decision, that they should have the choice, and because women would always opt for illegal abortions if it remained illegal, because it's so much worse when you have to do it illegally, it should be made legal.

I feel ambivalent about abortion now because although I still support a woman's right to choose the reality of legal abortion and the media reports about it makes me sad - all those babies. I also feel sorry for the emotional pain the women will go through. Having had an abortion, it has made me wonder, what else am I capable of? It really makes you wonder what kind of person you are that you can do something like that.

This is not something I could talk to a minister about. I wouldn't want to be judged and anyway I can't talk about it to just anyone. It's between me and God and I believe God has forgiven me because I can see His hand in my life, I just have to forgive myself. God is more forgiving than people. I think I have or am beginning to forgive myself but I haven't come to terms with the loss and I don't know if I ever will. There will always be the sadness.

m. Did your feelings about having children change after the abortion?

No, I had always loved and wanted children and I was broody for years before I had my son. I was worried that I might never be able to have children. It became an almost irrational fear. I thought God would punish me and I wouldn't be able to have a child.

n. What would you say to someone seeking an abortion?

I don't know because although I believe every woman should have the right to choose, I know how much pain I have suffered. Whenever I see a movie or read a book about someone trying to decide I always silently say "Don't". I think I would just try to be supportive. I wish I could say I would tell her about my experience but I still can't talk about it much although I am getting better. I would say this is how some women have felt because then it removes me from it. Sometimes I can talk about it clinically without crying. Perhaps I will get to a point one day when I can tell.

o. Would you have another abortion?

I would rather die. I know I would never cope emotionally or mentally. Since talking about the experience I have been having numerous vivid dreams about abortion, finding I'm pregnant and choosing not to have the abortion. I've also dreamt about my son, I dreamt I lost him on a ship and I woke up sobbing. I've also wondered how my life would have turned out if I hadn't made that decision. I also think if I had, I wouldn't have the son I have and knowing how precious he is to me, and not knowing the baby I would have had, I can, not take comfort, but the regret is balanced, because I have him. I can't explain it properly, I am just grateful that I have him. It does not take away the pain though.

APPENDIX 3

CASE HISTORY 2: MARY

Mary is 37, unmarried and has no children. She had two abortions, the first at 16, when she was sent overseas and the second five years later which she tried to induce herself.

a. How long ago did you have the abortion and how old were you at the time?

I was 16, it was 21 years ago.

b. The nature of your relationship at the time.

He was a doctor, aged 38, and I was a very naive 16 year old brought up in a very strict home. I was his patient, he tried to get into me and I backed off and then he then got me a role in a movie when I was 15. He got me the job, my mom was ill and money was tight. It became this kind of gratitude thing in this young, naive brain. I can't say I felt anything for him other than gratitude. I was too young for emotions. We used to have these little trysts in his rooms of a Wednesday afternoon and I never even thought in terms of pregnancy. If I look back now pregnancy wasn't even a word I had fully comprehended.

I remember going to work a few mornings and feeling very ill and he said are you pregnant and he sent me to a gynaecologist who confirmed it. He never asked if I was on contraceptives and when I look back now I think he must have been crazy. It never even crossed my mind; it was my first sexual relationship.

c. Your feelings and those of your partner when the pregnancy was discovered.

He said he had to tell my mom and I said, Oh, God, not my mother but he said he had to. He phoned her, got her into the rooms, sat her down and said, Mrs M, you daughter is pregnant. My mom went totally ballistic and I wanted to jump out of the window. He had said to me whatever I do, don't mention his name. He suddenly remembered he had a wife and four kids. My mom kept saying who is it and I said I can't tell you. When I think back I wonder how I could be so stupid and not say anything.

He had been our GP for a number of years and said to my mom, Mary is young and we don't want to waste her life, you can't really afford it. I will pay to send her to London for an abortion, you have to consider her life. At this point my mom thought this guy was absolutely wonderful. He had been so good to us, giving me the job but now I realised that had all been done with ulterior motives.

When we went home and thought about the thing, my mom went back and said look I don't think abortion is such a good idea, why don't we send Mary to friends in Pretoria and you can pay for the confinement and I can bring the child back and say I've adopted another child and no-one need know. He said no, you don't want to ruin her life. Of course then, obviously there would be living proof that it was his child should I one day decide to do anything about it so the best way was to get rid of it.

d. Making the decision.

At the time I was fine with it. It was so strange. Everything happened so fast. One day I was pregnant; within a week I was packed off to London; arrived on the Tuesday, on the Wednesday I was in hospital, had the abortion and on Friday I was back on a plane to East London.

e. Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?

I wasn't told. If they did tell me, I don't recall. I was two months at the time. I think it was probably a D&C. He said if I had come a week late it would have been too late and hence the rush.

I would possibly have wanted the information, yes, if I was older but if this happened with the second abortion, yes, then I was at the stage of wanting to know what they were going to do to me, wanting all the information. If it were to happen today, heaven forbid, I probably wouldn't make the same choice, I would want to know exactly, what are you going to do, does this foetus suffer, I would want to know everything about it. Then I was too young to fully comprehend. He may have told me what he was going to do but it obviously didn't mean enough to even register. Nowadays with abortion being legal, I think counselling would be wonderful, especially for 15 or 16 year olds.

f. The abortion itself.

It took place in a hospital. When I arrived in London I went straight to the doctor's rooms in Harley Street and he booked me in for the following morning. I was there at 8am and they took me in at 11.45. Strangely there was another girl from South Africa who was in the same ward. The hospital had thick rubbery plastic doors that were yellowed with age and a bit frayed at the bottom and I remember saying I don't think this is such a good idea but inside it was fine.

There was a telephone next to the bed and TV. I was impressed. At that stage we had only had TV for about a year. It was all exciting. I don't think I had fully comprehended what was actually going on, it all happened so quickly. The life inside of me meant nothing to me. It was this wonderful experience of being in London.

They treated us very well and by about 5 I wanted to go. As I came round and they pushed us into the recovery room I asked what they had done to my friend. When I got back to my room I asked where's my food. It's wonderful being a child. The doctor wanted me to stay over but then he gave my friend his phone numbers. Walking out of the hospital it was pitch dark. It was the first night of my life that I drank. In fact I got totally plastered. I went and sat in the hotel lounge and just drank and drank. I was tasting gin and all sorts.

At about 2am I went back to the room and at about 3 I started getting these terrible pains and I was screaming with pain and my friend phoned the doctor who said he had expected it and she must run a hot bath and put me in it. As soon as I got in blood started pouring and then I was fine. The next day I was up and sight seeing and the next we came home.

g. Your feelings afterwards, immediately; several years later; after having children.

I was fine, it was wonderful. I was 16 years old, never been on an aeroplane and suddenly I was in another country but about four months down the line, that's when it hit me. I had been in my bedroom and walked into the kitchen and just blacked out. When I came round I was hysterical. I got to the stage where my mother had to take all the baby photographs of us and put them away.

I couldn't face seeing a pregnant woman or babies. I went totally ballistic for a while and this carried on for three or four months and then one day I thought, hey wow, it's not their fault, it's not the pregnant women's fault what happened to me.

My mom was phoning every guy I ever knew to find out if they were the father of my child and it was quite embarrassing but I still stood firm I didn't want to tell her. She came to my room the one day and said the only way you're going to deal with this thing is if you tell me who it is and I said, mommy I can't,

and then she said, is it him, the doctor. By then she had been able to sit back and think, why should someone go out of their way to do this for somebody they don't really know. I said, yes it was, and then a friend of ours who worked at the magistrate's court suggested we sue him for statutory rape and I said no. Regardless of how naive I was, how innocent and how he had taken advantage of me, he didn't rape me. I was a willing participant, no matter how ignorant. I said I just wanted to get it over with, I just want to forget about it and put it out of my mind. And that was it and from there I started picking myself up and carrying on and realising that life had to go on.

I had the abortion in November and my baby would have been born in June, it's so ironic we're finally meeting in June. There was a time for years in November and June, things would get to me. It's only over the last three or four years that I have found November and June comes and goes without remembering it anymore. Then I used to get extremely depressed, particularly in June. The November would remind me of what I had done whereas in June it would be a case of I could be celebrating my child's birthday with him or her now. That's what used to get to me but time passes and other things take over in your mind.

Strangely enough it was in March that I aborted myself (the second pregnancy) and the child would have been born in November but strangely enough that I put out of my mind. It's always been the first one that had more impact. In November I always think my child would have been...I could have a 20 year old and a 13 year old.

My parents were extremely intimidated, coming from a poor area of town, not having the power, the money to fight. She was very upset but by the same token, I think it was a mixture of gratitude that, regardless that he was the cause, that he had sorted it out. She was intimidated by his power and position and wealth and she was not going to take this man on and strangely enough I went back to work with him and he wanted to carry on the relationship. Initially I was stupid, I did but then it kicked in and I thought, no why am I doing this and then strangely enough divine justice eventually occurs. I had been back at work for six months and I took very ill and ended up in hospital and while there heard the nurses all whispering that he had been struck off the medical role. He had got into trouble. He came to see me in hospital and said, I'm sorry, you don't have a job. He had been running an illegal black practice in the Transkei and one down town and his gardener had been dispensing medicine. He moved to Pretoria.

Strangely his wife had found out that he had paid for the abortion. An acquaintance of my mom who went with me to London because my mom couldn't as my sister was only two, this woman took Mandrax and blackmailed him for it when she found out he'd paid and one day she phoned his wife and told her. Then we had he and the wife pitching up at our house and she said, my husband had to take his hard earned money to pay for your daughter to murder her child. I wasn't home but my mom said he was tramping on eggs he was so scared my mother would say something but at that time my mom didn't realise he was the father.

But in the end justice ended up being divine and he lost everything. I'm so glad I didn't cause his down-fall. I'm not glad it happened but I'm not sorry it happened. I'm glad I didn't bring him down, regardless of what he did to me, I don't have to live with it for the rest of my life that those four kids who were innocent, that I messed up their lives for them.

Through the years I just learnt to deal with it and realised nothing is going to change it, nothing was going to bring my child back. Looking back, if I had had any choice, I would not have chosen the abortion because I started getting to like the idea of having a child but today at the age of 37 looking back I'm glad the decision was made for me. In retrospect it was probably the best decision. For years I didn't think so but now looking back I try to picture how my life would have been with a child. My singing probably wouldn't have progressed. I probably would have married the first man who asked me because I had a responsibility so I think that now that I have lived with it for all these years, I haven't missed it. My child would have been 20 this month but who knows how my life would have gone.

I was very bitter towards the doctor for a while but I can't really hate him for what happened and I don't hate myself for what happened, I was very innocent. It was an experience I went through. I like to believe it was one of the many bad experiences in my life that shaped my life and helped me to grow up and become a little wiser.

NOTE: Mary said she thought the ups and downs of her life, including being the victim of a battering relationship and her birth mother's negative interference in her life, had made a difference to how she had coped although the abortion had probably been the worst being so young and having to have to deal with that. She said she had two nervous breakdowns, the first after the abortion and the second at 19 after her mother "plagued" her life and, in conjunction with the abortion, it all became too much. She "lost it" one night two weeks after a close friend was killed in a car accident. Mary said she realised, however, that she had a choice to fold and live on valium or take control of her mind. She had an earlier breakdown at 14 also precipitated by her mother who constantly interfered in her life. At 19 she told her biological mother, who had tried to abort her and who signed adoption papers when she was seven months pregnant saying she was getting married and that the baby would be a hindrance, that she never wanted to see her again.

It hasn't been easy but you come out of it stronger.

h. Did you have any type of counselling before or afterwards?

No, none at all. I've told a few friends but not many, it's obviously not something to be proud of.

i. What was useful, what was not?

What I would have liked more than anything was a mediator between me and my parents. When I say a mediator I think of the way that man sat her down and told her so bluntly that I was pregnant and her going ballistic. I couldn't bear the thought that I had inflicted this on my mother. I would have liked someone there to first speak to me and decide what we were going to tell my mother not boom, like it happened. To have somebody there to break it to her with me. That's what always sticks out in my mind about that entire time. I think that is important for young girls who are still facing the parent syndrome; to have somebody there sympathetic to them and to the parents. I didn't know how to deal with her, I just wanted to put my arms around her. I remember crying and saying, Mommy, I'm sorry, I'm so sorry. At that age and left with the thing you've just heard and still trying to cope with your mother and calm her and you don't know how to do it. That was the most devastating time for me was my mother finding out.

j. What would have helped?

I would have liked someone to sit me down and discuss my options. When my mom, my dad and I discussed it at home and she decided on me going to Pretoria, I quite liked that idea. I would still have my reputation, mom would come back with the baby who would now be my sister, I'd have the baby but not the responsibilities because my mom would adopt the baby legally. We would discuss this whole thing - it's amazing how quickly you grow up - one day you're a naive child and suddenly 24 hours later you're an adult but when she went back he had the power, the money and it wasn't even an option to him.

The second time I don't know if I would have wanted to, my biggest thing then was to keep it as secret as possible so I doubt even if I had a choice I would have. I just didn't want anyone to know.

Now I realise that if there was someone it would be wonderful to talk but at the time I was so caught up in this fear and even though I would have known it was somebody, I would have thought, how can I trust them, I don't know them well enough to trust them. What if they phoned my mother and said I'm worried about your daughter, she might overdose, so I doubt if I would even have trusted anyone as the big point was secrecy.

It wasn't really an acknowledgment of pregnancy. I never even bothered. The father asked how far I was and I said I didn't know and he said well, shouldn't I go to the doctor and I said, trust me I know. I think it was knowing it and just not wanting it to be and to happen. I never thought in terms of the pregnancy, just getting rid of it. Don't think of the implications. Don't think of the fact that hell, you're 24 years old, so what if mom has a fit, you're a big girl now, you're working. None of that crossed my mind it was just, I've got to get rid of this. It was like a panic, an absolute panic.

k. Who else knew/did you talk to?

Some friends.

l. Did you have any religious or moral views on abortion before the termination or after and did these change?

No. People in the office were discussing it the other day and I said I had no opinion. I can't say, yes I'm for legalised abortion but I cannot be against it either. I think it depends on the situation. I think it should be legalised but I'm also so scared that it's just going to open the doors and for it to be used as a contraceptive method.

I have had so many situations that have brought me down that I have grown strong. I'm fortunate that I've been strong enough to cope with it and pull myself through it but I look at young girls today and I just feel that if abortion is so easily available that they can and do what they like and have an abortion but it is going to screw up their minds eventually even if they don't think about it at the time. When you're young it means nothing to you, you're a baby yourself. That just frightens me. I'm a little bit against making it so easy to young girls.

I've always regarded myself as a Christian. There was a time when his wife came and accused me of murdering my baby and I thought about it, but I conned myself out of that thought process of doing wrong. I stopped going to church. It got to me. I felt so disgraced, and unworthy, yet I don't think it was conscious, it was always like a subconscious thought. Then I conned myself into thinking that if it was meant to be it wouldn't have happened. They would have done the abortion but it wouldn't have been successful and I would still be pregnant and this is how I conned myself into thinking, right, fine God's not going to send a lightning bolt down to strike me and yet, to a degree, as we were talking earlier about punishment and would I have a kid now, it's still played a large part, so I obviously didn't convince myself entirely that there was going to be retribution for it.

I now go to church. It all started with my father's death in January (six months previously). I realised I needed something in my life and I started going and finding, I can't say exactly an inner peace, but certainly finding myself a lot more tolerant of a lot more things and actually just enjoying that solitude and oneness with God. It's going to be a long process and not just happen overnight - on the road back. I've never blamed God, sort of, how could you let this happen because I had choices. I'm fine with it now, looking back on all the ups and downs over the years finally I can look back on it and stop beating myself up over it.

m. Did your feelings about having children change after the abortion?

I don't want children, I think I've got too old. I love children and have two stunning nephews and a niece but if I tried to analyse it, I think now I can't. There's something I need to tell you which very few people know about. When I think about my life I think I can't believe the things I've done. I aborted myself again at the age of 24. Even my family does not know about it. I think why it affects me more than the initial abortion is because this was a decision I made and it was a difficult thing.

I was going out with this guy, we had a wonderful relationship, he was always begging me to marry him. We hadn't got into a sexual encounter and it sounds so cliched and bizarre but the first night we connected I got pregnant. I couldn't go back to my mom and say guess what I'm pregnant...again. I should

have learnt my lesson, I should have known better. I should have, after what I'd gone through, getting into a sexual relationship I should have taken precautions and for some strange reason I didn't. And then I thought, well that's it. I phoned the guy and his first reaction was well, don't expect me to marry you and I said, I don't.

I said there was no way I was going to go through this alone and face up to my family and friends again eight years later. I said I would deal with it. I remember taking five quinine tablets but all it did was make me pass out in my office and make me think I was dying. Then I remembered a friend saying years ago that if you want an abortion have a loop fitted so off I went to a doctor and told him this whole story about going away for the weekend with a new boyfriend. I was desperate, I didn't know if this would work but I was desperate to try anything. He wasn't too happy about it but he duly did. It was about three weeks after my period. The strangest thing was I never had any confirmation of my pregnancy, I didn't go to a doctor, I just knew that I was.

I actually think that doctor realised what he was doing because of what he said afterwards when about a year later when I went to have a loop fitted, I remember him saying you're not pregnant this time, are you. That was on the Friday and by the Monday I had started haemorrhaging quite badly. By Wednesday I had clots the size of fists and I was getting weaker and weaker but I still couldn't tell anybody. On the Friday my mom had gone into town and some of my fingers started to go numb and I started to panic, this is it I'm going to die and die alone. Then my mom came and found this screaming hysterical mess on the lounge floor. I didn't mind about the fact that I was dying because I thought at least my secret would die with me but I didn't want to die alone. My mom said, hospital straight away and off we went.

The one friend I told I said, my mom mustn't know and she said she'd keep her away. The doctor said, you realise you're pregnant. But what had happened on the Wednesday already was that the loop had bled right out. I still have it as a souvenir to remind me not to be stupid again. I stuck to the ignorant thing, that I wasn't pregnant. I said I had started bleeding as a result of the loop and I thought it was normal. I was given about three pints of blood. They gave me a D&C but it was very painful beforehand and then I was fine.

I never told anyone except close friends and my family still don't know. That is one of the reasons I don't want children, I don't think it would be fair. I know it's stupid to think like that the other two don't know the difference but it just seems like, I think I'm also a bit scared maybe that if I had a child I'd probably end up with a deformed or retarded child, a kind of a punishment and my age. I think I've just kind of programmed myself into not wanting children and I really now don't want children because I don't want them but I think the whole initial reason behind it was that. Today I don't think in terms of the abortions but I think that was the whole factor that led me to programme myself into not wanting children.

The father was pissed off that I did it. What pissed me off was his reaction, don't expect me to marry you. I phoned him afterwards and he said he was going to send a card but didn't know what to say so I said, what about, I'm sorry, not sorry that he didn't want to marry me but sorry that he couldn't stand by me when I went through it. I went through it on my own with my friend.

Afterwards she gave me a little trinket box, I don't know where she found it but it was so appropriate. The lid said free again and inside the wardrobe doors were open and it was completely bare and said back to being me again. Totally barren now and empty, the most appropriate thing.

The relationship then ended but about three years later we met up and at a braai there was a two -year-old child running around and he said, that could have been our child and I said, yes, but it isn't so don't even talk about what could have been. It's not and never going to be so just forget it. He said he thought we could live together for six months and see how it went and decide from there whether we wanted to get married or not but I had to make a decision quickly because what if I did and after six months you decided you didn't want to live with me and kicked me out, I'd have sat holding the baby to face all of this again, tell everybody about it, face it all on my own. I had to make a decision in a hurry and I just decided to go

with what was best for me at the time. I'm not particularly happy about it but I made it and have to live with it.

It was very difficult going through it at the time and what was worse was the fear, the absolute terror of my mother finding out. Fortunately from a young girl I had always had menstrual problems and had needed treatment so I had the perfect excuse. She said, well then you must get the doctor to put you on the Pill to regulate you, and that was the perfect excuse to go on the Pill without mother asking why but then I thought I'd just get the loop because later she might forget what she'd said and wonder why I was on the Pill. I think my mom would have been terribly hurt (if she knew), it would have totally devastated her and I think it would have killed my father the second time round.

The first time was hard enough for them to deal with. I have no doubt they would have stood by me. I saw how devastated they were the first time I just could not put them through that again. I made what I believe to be the best choice at the time which is a total contradiction in terms because I said when I was 16 if I had the choice I wouldn't have made it. The second time around it was like a desperate thing. It was so much easier the second time around to make that decision.

n. <u>What would you say to someone seeking an abortion?</u>

Think about it very carefully. I consider myself lucky that I pulled myself through it but I do have an extremely strong mind. Unfortunately not everybody has that and I would say think very, very seriously because once it's done, it's done, there's no changing your mind. You can have your baby and decide to put it up for adoption and before the final date say no or you can decide you're not going to give it up for adoption, keep it for six months and down the line say, I really can't cope with this child, I'd rather give it to someone who can. You still have choices. With an abortion it's final, you can't change your mind. It's too late. It's such a final, final thing.

The decision has to be made immediately, you don't really have time to think about it. But I would say take at least two or three days, it's not much time, but it gives you more time than making that decision on the spur of the moment. Because what happens, I've proven with myself, it never ends, you carry on. The second pregnancy wasn't even thought of as a pregnancy it was just abort, get rid of it, it became easier. It's not emotionally easier.

Even though you live with it, you cope with it, I'm fine with it now, it's wonderful. There are certain things, in certain ways it has affected me, and has affected my life even today, not ever having had a child thereafter, which I'm not missing, but it certainly has and emotionally to a degree, it was final, and thinking now it's still there in terms of, I could have an abortion again if I chose to, it would be even less stressful than the second time because I've been through it twice already and you're quite blase about it, sort of a veteran at this now and that in turn you become quite a callous person within yourself in terms of you thinking, oh well it doesn't matter if I fall pregnant, I know there's a way out, no sweat at all.

Look, I don't know if I will ever have an abortion again if I fall pregnant but there could be a part of me that if it happens that would become callous and say, oh well why not, so show me something I haven't done. (Interviewer noted that callous was a harsh, judgemental word) I always try to be realistic about myself and I'm extremely critical of myself and I think that has helped to keep me on an even keel.

I think why I do that is because prior to the first pregnancy and the subsequent turn of events I was quite a big headed bitch. I thought I was God's gift to humanity. I had a nice body and guys used to whistle and then I fell with such a bang. It brought me down and made me realise that I wasn't that wonderful person that I could do whatever I liked to people and nothing would ever happen to me. I owned the world and it made me realise I was a part of the world. It knocked my self confidence completely and it took a while for me to start building up and becoming my own person again. I think it has made me extremely humble and maybe a little too self critical but it's something I'll always hold onto because I'm also scared that if I go and get carried away on this, I'm miss wonderful again, the consequences would be awful.

But if I think if I had my life over again I must honestly say there is little about the bad things that have happened that I would change from where I'm standing today. For what I've learnt, for what it has taught me, for how it's made me grow.

I always tend to choose the wrong guys. I always look for strength in a guy but unfortunately I look for strength in the wrong way, get the strong, real dropouts who are just strong through a bottle or a fist where what I'm actually looking for is a guy who has got strength of character.

I don't know if its maybe a subconscious punishment I'm trying to inflict on myself, deliberately going out and finding these absolute dregs of humanity and dragging them home.

o. Would you have another abortion?

I go cold thinking of it. I don't know. A year ago I had a bit of a scare and I remember panicking and thinking not again, I can't cope with this again. Then just thinking what the hell, I'm 36. I would have to face it and then make a decision but suddenly it didn't seem so important to think immediately of getting rid of it. It was a case of please don't let me be pregnant, this is all I need in my life right now. Funnily enough then I was in a show and thought this is going to throw me out, having a big stomach and things like that. It wasn't that panic of, it must go. I've got past the stage of worrying about what my mom would think although it would upset her but I don't think that would be a big thing.

NOTE: After the interview, Mary phoned to say she was faxing me some of the thoughts and the poetry that she had written about her experiences (See Appendix 7). She said she had a warm, cosy feeling after talking to me. She felt relaxed. She said she had never thought about her feelings before. She said it made her face up to how she felt. When the researcher noted that she had not cried she said she had learnt not to cry, to be strong, it was her defence not to cry. When her father died earlier this year she had not cried because others depended on her: "You can't break down, you have to be strong. I write them up, that's what I do."

APPENDIX 4

CASE HISTORY 3: RACHEL

Please note where brackets have been used this is what the respondent took out after reading it over.

Rachel had two abortions within months of each other eight years ago while on a working holiday in England. She is now 35, unmarried and has no children although she has subsequently miscarried.

a. How long ago did you have the abortion and how old were you at the ime?

It was 1989, I was 27. It was in July and November.

b. The nature of your relationship at the time.

We had been going out for about a year. He had gone overseas and I went to join him. He was five years younger than me.

c. Your feelings and those of your partner when the pregnancy was discovered.

Within a couple of months I fell pregnant. We were using condoms most of the time. I was aware of my cycle during the times we didn't. The first time it was kind of a decision that had to be made but the second time it devastated me. The first time it didn't really affect me. I was shocked when I discovered the pregnancy, I did a self test, but it was overshadowed by the second. We were shocked by the first and thought now was not a good time for both of us, we were away from our support systems, we had saved for so long and wanted to travel. It was a clinical decision, it didn't seem that emotional. My boyfriend did not want to get married, he was only 21, and neither of us wanted a child at that stage. I was angry with my boyfriend then, but I feel nothing now, I prefer not to.

d. Making the decision.

I was put in touch with a private doctor and it was all very nice and clean and easy. I was seven weeks pregnant and the doctor arranged for me to go in immediately. It was a very nice private hospital. My boyfriend took me in for the day and fetched me that night. The staff treated me very kindly.

My immediate feeling was of wanting to get rid of it. I didn't acknowledge it, it was a feeling of I want to get it over with. There was a sense of denial.

e. Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?

I was offered counselling but declined - I was warned it may affect me. It wouldn't have made a difference the first time.

f. The abortion itself.

I had a general anaesthetic both times. I think it was a D&C both times.

g. Your feelings afterwards, immediately; several years later; after having children.

I was upset for a few days afterwards. My boyfriend went out that night. It was a stormy night and I was feeling vulnerable, fragile, upset and angry. I've just realised that it was after that that he became violent towards me, it was shortly after that. I was not too devastated by the abortion (the first).

h. Did you have any type of counselling before or afterwards?

I didn't have proper counselling before the first. I spoke to the doctor and he gave me options. It was not intense counselling but he said he could arrange counselling. I said I was 100% fine and sure. The doctor said I must go on the pill but I always hate being on it as I resent the effect it has on my body. We used condoms and within a few months I was pregnant again.

I was shocked and devastated and thought how can this be happening again. I had just gone to Turkey on holiday and thought I was sick from the food and water. I cried and cried in the bath. I was absolutely shattered. My boyfriend was not anywhere near supportive. He didn't want to know or talk about it. He said I must sort it out. It was dreadful. I was shocked. I thought I can't do it again. I was in the same situation, I didn't have any option. I didn't think I could cope. There were problems in the relationship, he had hit me a few times, shook me and threw me around. I was terrified. I stayed because I was in a foreign country and he was my only support system. How could I come back and get a job being pregnant. I was clinging to the relationship. I didn't want to do it but I thought I had to because I knew I couldn't cope with it on my own at that time - I was a mess.

I had problems with money so I had to go on the NHS (National Health Service) and to an abortion clinic in London. The doctor said they didn't know if I was pregnant again or it was left over from the first abortion. He said you have got to be one of the unluckiest people I know. He told me my options but I don't remember being offered counselling.

The second time was a horrible experience, the way I was treated. We were all there for the same thing, we were not treated badly but you couldn't get away from the feeling. It was subtle. There was a contempt for the people who were there. The nurses were professional though. Everybody talked about their stories and that was a support. The care wasn't that good. The first appointment was cancelled so I was 10 weeks and I was aware of being pregnant when I finally had the abortion.

I was convincing myself I had support but I had no support. I caught the train into London and used a map to find my way. I was crying, sobbing my heart out and I had nobody to confide in. My boyfriend's brother's wife gave birth two weeks later and nobody knew about me. I found that the hardest. My lifeline didn't want to know, he had distanced himself so I got there being distraught.

I stayed overnight and they did a D&C. The next day I had to get a train back, he didn't meet me. When I walked in at 11am, he and his buddies were sleeping off their hangovers. All the implications hit me. I was devastated for months after and had terrible guilt. It was the injustice, the unfairness of it. I felt trapped and had no options. Within a few days I left and visited a friend in Cornwall and stayed a week.

There were complications and I bled for a long time. I had a lot of pain and was worried it was incomplete. I didn't tell my friend. It eventually cleared up and I had a check up. The first time there was a bit of sadness but there was also a sense of relief. The second time it was just awful - it hit me hard.

I went on the Pill the second time and a week later I moved out. My boyfriend was sweet and nice but it was the beginning of the end. I stayed and worked in a restaurant for a few months. He moved and I moved back with him for a couple of months. He felt guilty and responsible but he was seeing someone else, I know.

Four or five months later after the second abortion I came home to South Africa. It hit me hardest when I got back to my normal surroundings, when I was in strange surroundings I had to cope. When I look at how I was before I left and what had happened, I was a wreck, I was on sleeping pills and anti-anxiety and anti-depressant tablets. I was stunned and shocked. I was like a zombie.

I saw a clinical social worker and talked about it. I think it did help. I also spoke to lots of friends, I needed to get it out.

I bury things and have learnt to cope with this in a conscious way. Eight years later, I only occasionally feel sad and disappointed and a sense of loss. It does still affect me emotionally from time to time but it is not fresh anymore. Subconsciously, I think it has had a permanent effect on me. It has left its mark.

When the second pregnancy, both in fact, was discovered everyone (the doctor) agreed that my circumstances were not ideal. I had a terrible relationship and this was an extra load and I couldn't deal with it. If it was a different environment and I got support, it might have been different. In fact, I'm pretty sure it would have.

i. What was useful and what was not?

I don't remember but the biggest thing was being able to talk about it. I mourned the loss and had so many regrets. I cried a lot up to a year afterwards and begged for forgiveness. (In a way I think I'll always mourn.) I don't get emotional or upset anymore but (deep) inside there is a (deep) sense of loss.

j. What would have helped?

The decision should not be taken lightly at all. In a way it is better if you have a complete picture of what the effects may be. You need to have as many facts as you can before making the decision and enough information on how to deal with it afterwards. You can't undo it so you need to be as informed as possible and prepared to deal with it as constructively as possible.

It would be useful to be able to talk about it straight afterwards and up to a year or so later. A support group would be good.

There should be counselling before to enable the woman to make an informed decision and this should be provided by qualified professionals specialising in this area. I have read quite a few articles about abortion and I don't like the pro-life approach. Blowing up clinics and killing people is wrong and I don't think they have a right to (be preaching, to) make judgments and force their opinions on others. It is a hard decision to make and you need all the support you can get.

You need to be really clear in your own mind, you must be really sure and make as informed a decision as possible. Be prepared to take awhile.

I am a lot more reluctant to talk about it now, I want to let it go. (The respondent spent the first half an hour asking advice on a problem with her present boyfriend.)

k. Who else knew/did you talk to?

On my way overseas I talked about abortion to another passenger who is still a good friend and it is so ironic because I said if it happened to me I would never have an abortion. I was not anti or judgmental, I just felt I could never do that.

l. Did you have any religious or moral views on abortion before the termination or after and did these change?

There were very strong views on abortion in the environment that I grew up in. My family are very religious, very moral and abortion is a very big sin. I have not told my mom about the abortions. There was a fear to tell my parents about my pregnancy the first two times. The third time I fell pregnant I thought that's it, I'm not going through it again and they, my parents, were very supportive. I wanted the baby and was prepared to keep it no matter what, but I subsequently miscarried.

m. Did your feelings about having children change after the abortion?

(I don't want a baby that much anymore but) For years after I craved to have a baby. In a way to prove that I was a "worthy mother", had made a mistake and would never do so again. Trying to make up for the past. (I thought I never would have a baby. I felt never.) I would never have an abortion again. I was so excited a couple of years later when I fell pregnant. I felt it was a reprieve, that I had been forgiven. Now was my chance to do it right; I was getting a second chance. Then I had a miscarriage at 10 or 11 weeks and I was devastated. I was shocked. It was a non-viable pregnancy. I had a D&C at a private hospital. I was sobbing when I was wheeled in. I thought I was being punished. I thought God would never forgive me; I'd never forgive me. I panicked even more after that, I felt now I'm never ever going to have a baby.

I went for counselling for a couple of months. I don't feel it that strongly now, wanting a baby has got nothing to do with it. I still wanted those babies. The craving, desperate urge to have a baby has subsided. I still don't know if I'll ever have one. I'm now thinking that it wouldn't matter so much. (I'm pretty sure the feelings are not to do with the abortions, it's not to make up for the abortions.) I still feel sad about three pregnancies that came to nothing. If I knew this would have happened I might have made other decisions then. I still want to have a baby, very much, but I would prefer to choose the right time, circumstances etc. (This sentence was added on review by the respondent who told the researcher telephonically that she "really did" want a baby.)

n. What would you say to someone seeking an abortion?

If there are any viable alternatives, you should think very hard. It depends on your own conscience and values and circumstances. Most people are affected quite deeply. I have come a long way. I used to have dreams, often but not for years now. Quite a few times from time to time I would dream about a baby, that I forgot to feed it, that I had left it somewhere or that I had neglected or forgotten it.

o. Would you have another abortion?

No, not willingly. Only perhaps in exceptional circumstances such as rape.

APPENDIX 5

CASE HISTORY 4: NADINE

Nadine had an abortion four years ago. She went to London to have it. She is now 24 and is in a steady relationship with a different partner. She does not have any children.

a. How long ago did you have the abortion and how old were you at the ime?

It was on November 9, 1993. I was 20.

b. The nature of your relationship at the time.

I had just come out of a serious relationship with a guy who was much older than me. He had proposed and my dad had offered him a job but he messed me around. I was studying in Cape Town and went on a wild rampage and had a one night stand with a guy two years younger than me. I was on the pill (Marvalon).

c. Your feelings and those of your partner when the pregnancy was discovered.

When I told him I had to talk him out of killing himself. I was the one who had to be strong. I decided to keep the child. I told my parents and my father's immediate reaction was: you keep the baby or you get out of the house. My mother couldn't stop crying. I left the house to stay at a friend's house. A few days later they called me back and we discussed it further. They wanted me to have an abortion because they felt it would give me a second chance. I had an incredibly romantic idea of what it would be like having a baby but my parents brought me down to earth. They said they would pay and I could pay them back. Asked if she was angry at her parents she said she was not.

d. Making the decision.

A local gynaecologist arranged it for me in London. He did an internal scan. I saw my baby. I wasn't upset, I was glad I saw the baby, it was calming in a strange way. I wanted to go alone. My parents wouldn't let me go alone. My best friend came with me. Someone from the clinic fetched us and we stayed at a boarding house across the way.

I saw a doctor there who did a pregnancy test, then an internal examination and internal scan. I wasn't terrified.

I still wanted to keep the child. It was an incredibly difficult decision to make. Practically, you can't get too emotional, that will tear you up. I had a week to make up my mind and a week to get to England. You need to know how long you can wait. None of this information is available.

e. Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?

The doctor explained the procedure. I wanted to know. I felt secure in the knowledge.

f. The abortion itself.

I went to an abortion and fertility clinic. The nurses were magnificent and supportive. It was run by nuns and they were incredibly supportive, they went out of their way to be kind. They even sent a South African nurse to see me to make me feel comfortable.

It was very much like a production line. They put you in a paper outfit. There was this very big Jamaican nurse. Just before I was anaesthetized, the doctor made me hold the syringe. That's when I got scared and started crying. I said I wanted my mother, the nurse calmed me down, she talked me down. I made the mistake of sitting up and saw someone else having an abortion through the window in the door. It made me very scared.

When I woke up in recovery I swore at a male nurse but I later went back and apologised. He said he get's a lot of it and he understands.

I was not all that sore, it felt like a very heavy period. Every four hours they checked my pad and gave me paracetamol. I left the next day. I was 10 weeks pregnant and had a D&C. I had had terrible morning sickness during my pregnancy. It was horrible.

g. Your feelings afterwards, immediately; several years later; after having children.

Two years ago I would sit at my desk and start crying. There was stress at work, and in my relationship, it was not only the abortion. Immediately afterwards I felt extremely relieved, it was done, the decision was made.

But there is a battle between myself and God. I don't consider myself a Christian. I have to forgive myself though and sometimes I do and sometimes I don't. You never forget you have had an abortion. You have got to pick yourself up and deal with it and carry on. My doctor gave me anti-depressants two years ago when I went for a check up but I didn't like them.

I went to a psychologist for two sessions but she was terrible. She tried to create problems where there weren't any. The abortion was very hush hush and I don't discuss it with my family. They are embarrassed by it. They put me on a pedestal because I always achieved and now they are disappointed. They wanted the ideal for me. The psychologist wanted to focus on my relationship with my father, we argue a lot and he pushed me too much. We can't be best friends. She wanted to know if I had been molested. It had nothing to do with the fact that I had an abortion. I was angry that she didn't show or teach me any skills on how to deal with having an abortion.

I allowed myself to grieve: you had a child and you lost it. I didn't put the blame on anyone else. I told myself it happened and only you can pull yourself together. The father was glad and offered financial help - it cost about R2 000 for the abortion and R11 000 in total - but he never paid. We are not friends anymore and he's married. I'm absolutely disgusted with him and very shocked that he never stood by his word.

The day of the abortion, I remember it so clearly. It was the most difficult day in my life. Your emotions and thoughts are running wild when you are waiting to be wheeled in. I always look at kids the same age. You'll always have that, it is just how you deal with it. I don't burst into tears anymore. Three of my school friends had babies and they were very nervous of my reaction to their children. They all knew I had an abortion but it has been great. My one friend asks me and says she hopes it doesn't make me upset. We talk about it, you can't brush it under the carpet.

h. Did you have any type of counselling before or afterwards?

I was given about five minutes counselling in London which surprised me because surely they should discuss with you what is going to happen. It was just a formality, they asked the reasons.

Afterwards I was given a piece of paper telling me to expect to be depressed, suicidal or want to get married.

There should definitely be follow up counselling and an option to go back.

i. What was useful and what was not?

I went to the Family Planning Association (FPA) in East London before and they were incredibly judgmental and wanted to know how long I had been going out with the guy. Their business is not moral issues, they should just give you the facts. Give you the options and the pros and cons.

j. What would have helped?

Ideally you should have at least two sessions before and speak to someone who is completely objective.

Once you have made the decision and you go ahead with it you should speak to someone whose had an abortion and speak to someone about what's going to happen to you physically and emotionally.

Having information is important. If I was pregnant now, I wouldn't know where to go or what to do. If you go to the FPA you get bogged down. Do you go to your GP? What about people in rural areas?

Support groups would be excellent. I went to a single parents' support group before. I would like to join a support group. I'd also like to read more about it.

Women must be asked if they want to speak to someone. The person must be trained in counselling.

If people don't want to deal with it they must refer you to someone who will help. The service should be free, clean and hygienic. I would not want to go to a state hospital like Frere.

k. Who else knew/did you talk to?

At the time there were rumours that my friend had had an abortion so I cleared it up. I don't make it a secret if I'm involved with someone. After the abortion I lived with someone and he was very supportive. That was for about a year until four months ago. His reaction was fine and we discussed what would happen if I fell pregnant. Two months ago I met someone else and he's very supportive and wants to talk about the abortion.

l. Did you have any religious or moral views on abortion before termination or after and did these change?

Before I knew I was pregnant I was grateful that I had never had to make that decision. I was always in two minds about abortion. I always thought that when a decision is made one should consider the circumstances but I still believe the decision lies with the pregnant woman. She is the one left to live with all the repercussions either way.

Asked if she had ever dreamed about the abortion or baby, she said no.

m. Did your feelings about having children change after the abortion?

I love children. I want as many as possible, as financially possible.

I worry about being punished, that I'll have a deformed child. What if I can't have a child.

I stopped praying afterwards. I feel like I didn't deserve that release. Your self-esteem goes for a loop. You feel worthless because you have done something terrible. You expect a lightning bolt. You don't deserve to be happy. I've always had self-esteem problems.

n. What would you say to someone seeking an abortion?

I wouldn't advise them either way but I would tell them what happened afterwards and what happened with the psychologist. I wanted to speak to someone who had heard horror stories. I also wanted to speak to somebody who had a bad experience and somebody who had a good experience.

o. Would you have another abortion?

Yes. It's four years down the line and quite honestly it didn't affect me quite as badly as I thought it would. Each person is different. It may affect somebody else badly for the rest of their lives. If my circumstances justified another abortion, then yes!

APPENDIX 6

CASE HISTORY 5: KIM

Kim had an abortion two years ago. She had it illegally in Cape Town but it was carried out by a doctor who had performed legal abortions in England and hence it was done correctly. She is in a stable relationship with a new partner.

a. How long ago did you have the abortion and how old were you at the time?

Two years ago. I was 24.

b. The nature of your relationship at the time.

When I fell pregnant it was my own fault because I wasn't using contraception. I had gone to Cape Town to be with my boyfriend who I had been going out with for five years. We had a rough relationship and he had been unfaithful a few times. But I hadn't spent a lot of time on the relationship and I thought it was just one of those things and it wouldn't happen again. When I got to Cape Town he had been seeing a girl he was staying with. He said it didn't mean anything. And then I missed the golden opportunity of my life which is why I think things went bad. At that point I should have realised I'd made a big mistake, this guy wasn't going to change. But I stayed on.

It was a very unsettling and emotionally traumatic time moving there, adjusting and looking for a job and not having much support in Cape Town, not knowing many people and with this background of the relationship. The whole thing is just in this cloud.

I had always been very paranoid about contraception before this. I was very, very careful and paranoid and suddenly something changed and I lost control. I wasn't using contraception but I was constantly trying to get it right. I'd start taking the Pill, I'd be taking morning after pills the whole time. It was a vicious cycle so it was inevitable that I would fall pregnant under those circumstances. That was my fault for not taking control of the situation.

And the reason why I think counselling is of the utmost importance is when I speak to women who have abortions, and once you've had one you realise there are very many people who have had abortions and it's not such a strange occurrence, it's just that people don't speak about it. But, of course, once you've had the experience, people are more keen to talk to you and it's easier to communicate with other women about it.

This contraception becomes a very big issue even after you've had an abortion. I often ask myself why there are so many friends of mine - and it also happened to me afterwards - that after you've had an abortion and this was the worst, most devastating, traumatic experience in your life, why couldn't you get the contraception thing right afterwards. It was like women became...hey lost control, it's like they couldn't take control of the situation. I've got a friend now, she's had three abortions, she constantly has abortions and she still can't get the contraception thing right.

The one way that I see it because, immediately when I sort of became sexually active, which was only a short while ago, I also couldn't use contraception. It's like a big cloud covers the whole issue and I think it's because of a lack of counselling that you are in a denial stage. Either you want to purposely punish yourself and you're hoping you're going to fall pregnant to kind of get out all those demons or else you're just not dealing with the issue of contraception at all so you just ignore it. Which means you're not taking contraception and the thing happens again, it just becomes a vicious cycle.

I think there is a subconscious reason why you want to fall pregnant again because why does it become so impossible to use contraception. That's why it's so absolutely crucial for a woman after the abortion to deal with this issue otherwise there is a big chance she'll have an abortion again. I'm convinced of it, just

looking at my behaviour and how difficult it was to get the contraception thing under control. First of all I didn't want to take the Pill because I smoked and it's a danger and I don't like hormone manipulation because I feel ill. The condom is difficult at the best of times. You can use it for a short while but not constantly as a contraception device. But I think basically we don't have a good enough method of contraception. There's a problem with each one. I don't think society spends enough time thinking and worrying about contraception.

It's something that women take care of and also in relationships, it's not something that's dealt with. I don't know if it's a South African thing, it's not dealt with properly and openly enough for it to become something that is natural and right. It's so clandestine and cloak and dagger. It's a very difficult issue which is why I'm quite excited about this new contraception that has come out in the UK. (A machine that indicates when it is safe to have unprotected sex). I think if you look at how much technology there is and how much scientific innovation, why...? I went to the doctor when I finally decided to do something about it and asked him to explain to me what is the best contraceptive device, I want to know, and everything seems so inadequate. If you look at the last 10 years what great strides have been made, not much. But I eventually settled on the diaphragm and I've been using it religiously ever since I started.

One of the reasons also was I was afraid to go and see a doctor and gynaecologist. That I think can be related to having bad experiences with trying to arrange an abortion which was illegal. It's also a very painful experience so I had a thing, I just couldn't go to a doctor. In fact after this whole thing I developed this very bad thing I could only go to a homoeopath and a female doctor. I developed this total phobia, I'd sit in the doctor's room and I'd start quivering and getting really scared. Just that kind of male thing, the way they look down at you, sorry my dear you have messed up. We're going to have to fix this little problem but now it's my problem, type of thing. It was this whole fear of going to the gynaecologist plus the fact that certain issues of my abortion I haven't dealt with properly.

But then I thought the best way was to speak to my boyfriend about it because - my fiancé now - I left my first boyfriend after it all happened which was the blessing. My fiancé, at the time, we were friends and so he knew about the fact that I had an abortion. But I felt I was a kind of a fake, I was someone that wasn't really real because I had done this terrible thing so I wanted to speak to him about it and just bring it out in the open and once I had brought the whole abortion thing into the open and he dealt with it marvellously. This was when we started going out. I had an abortion two years ago and we got involved at the beginning of the year (1996, a year later). He's been very, very supportive. In fact the whole thing, meeting him, was what really kind of helped me finally deal with the whole issue.

I didn't really think that anybody would love me or I didn't think that I could have a sexual relationship with anybody. Because you're actually going against, you can't deny that you're going against nature. It's something anti-female because pregnancy is so much woman and to terminate your pregnancy you feel almost unisex. It's like you've made some kind of decision about not being a woman anymore. It's a very strange thing to deal with.

Immediately after I had my abortion I developed a big problem with sex. I couldn't even watch people kiss on a soap opera. It revolted me. I had this fish tank and these two fishes were starting to make these mating moves. I took them and froze them and flushed them down the toilet. I couldn't bear to watch anybody mate. That whole thing, suddenly sex wasn't an enjoyable thing, it has consequences which was another thing I was quite angry about. When you have sex that is what is the result of it which is why contraception is not properly taken care of. It's like you want to ignore that, it's not nice to think of all that. Sex is romantic and love but sex makes babies and once I was confronted by this harsh truth, that this is what the ultimate purpose of it is and where it all leads to I was quite disillusioned and disgusted with the whole thing.

Plus which, something which I realise is quite normal afterwards, being poked and prodded and with all these instruments and all these investigations, I just felt like I didn't want any kind of contact with anybody, I had to reclaim my body for myself. So the thought of being intimate with someone was

terrible. I actually thought I'd never ever have a sexual relationship with someone. At the back of my mind I thought this is just something that I'm going through that eventually I'd realise this wasn't going to be permanent because it's not possible to be like that.

My fiancé and I were very good friends at the time of the abortion but we only got together this year because he went away overseas. I think that is one of the reasons, because my ideas of relationships have changed completely since I had the abortion. The whole sexual dynamic and adventure thing is gone and now what I'm looking for is a friend, a partner and a more oatmeal kind of relationship as compared to a romantic idyll and something that has value from day to day and which is lasting and which might not be all that helluva exciting but it does become exciting but in a different way.

So then when he came back from overseas I realised, because he was my best male friend and he's always liked me, he's always wanted to go out with me but because I always just liked him, it wasn't that kind of 'wow' feeling, I thought no. This wasn't for me but when he came back I realised my ideas about relationships had changed and I realised I actually did like him. And he had gone overseas and he had changed a bit and I missed him while he was away. And when we saw each other we hit it off immediately.

c. Your feelings and those of your partner when the pregnancy was discovered.

My other boyfriend was my first serious boyfriend. When he found out I was pregnant he was very devastated and very shocked. Well, it was quite difficult for me at the time, and what helped me a lot was I recently read a book written by a British author, (Davies 1991) it was the only book I ever read on abortion. I was going to the public library and it just had abortion in big letters. So I read it and it was people's experiences. It was very useful because it made me realise that my experience wasn't unique because that's the problem of being so isolated with an abortion. You think you've really resolved feelings and your traumas and you think this is so terrible and this and the next thing. Meanwhile if you compare it to other women, which will be useful in counselling, you realise that this is like a process where at this stage...I mean it's not written in stone and the process is completely changeable but most people have the same experiences, the same way they deal with trauma.

All I know is that when I fell pregnant it was the worst thing that ever happened to me and the last thing on earth I wanted was this child. This must get out of my body right now because this is not right. This will be a total disaster. It's not like an actual thing that I weighed up, can I support it, this is how much I earn. It was just my God, this is terrible.

d. Making the decision.

I was the one who arranged everything. And he said whatever you want me to do just ask etc etc. I didn't want to get married, not at all. What I realised from this book was that they said that there were different types of support, one was someone who was just totally against it, one that was very supportive and the other one who was there but didn't really give any support, everything is up to you, whatever you choose is fine which is basically no support at all. And he kept on saying, no you know this is very difficult for me too, and I kept on going, I can hardly even look after myself and this person wants me to extend myself for him, and I didn't have anything to give to this person right now because I felt I was battling for my existence.

I've never felt so threatened and this person still wanted me to look after him while I was going through this experience. Meanwhile, this was the time for him to give support and that's where I think my ideas of relationships changed fundamentally. I always thought a couple is you get together and you share things and when the shit hits the fan you're there for each other. Then I realised if you fall pregnant you're on your own. There's no such thing as a couple, there's nothing that can protect you from the world, you're on your own completely and utterly. There's no relationship, nothing, no partnership. There's certain things that you face alone, that you deal with alone.

And I always thought that he would be there for me because I was the one who always gave far more than I ever got in the relationship. I realised when the shit hit the fan he was still expecting and not giving and I realised this man is not for me, he's just a waste of time. But I still could not let go of him because it was such a long and involved relationship. But then, when I sent him away to his parents and said look I just can't deal with you, I can't look after you as well. I was also supporting him financially.

I was working and it was so hard going to work with all this on my mind. I actually resigned three days after I had the abortion. There was no way I could go back. I just needed to take off. I was working at a PR company and it was dreadful, I was hating it. Then he went home to his parents and came back after three months and he thought everything was going to be fine and he was going to fall into my arms and I just said to him - and I couldn't bear to touch him, I couldn't bear to be around him - at that stage I had come back to East London and he came to live here and after awhile I said, look, there's nothing left, I really don't like you anymore and then he left. I basically had to kick him out though. I learnt a lot out of it.

e. <u>Were you told how the procedure would be done or how you might feel afterwards? Do you think this would have made a difference?</u>

It was very difficult (to arrange the abortion) very complicated because I knew nothing about getting an abortion. I was quite judgmental about people who had abortions before as well and then suddenly I was pregnant and had to deal with it. I knew this friend of mine who lived with me in digs and she was a feminist at Stellenbosch and very, very active. I phoned her. I was two weeks pregnant. It was strange I just woke up one morning and I knew. So I phoned her and she put me in touch with a few feminists in Cape Town who, it was strange, I never met them, I met the one face to face only, they were all journalists and then I just phoned them. They also couldn't tell me where to go or who to put me in contact with but they were very supportive and they were people I could turn to because they didn't think abortion was a terrible thing. They were on my side, whatever I did they were on my side which was good.

That was one of the most dreadful things, the realisation, and I read it in that book as well, that it was a complete loss of childhood. Actions have consequences and you have to deal with them. Your mother can't help you, your boyfriend can't help you, society can't help you, nobody can help you. When I was at university I was still young and a child but suddenly from one day to the next I had grown up and it was this terrible loss. I'm now grown up. It was a terrible feeling, it was very harsh. I think that was the greatest loss of the whole experience, not the abortion itself but this whole, actions have consequences.

So then I tried a few places (doctors) which was really humiliating, incredibly humiliating. The first one was in Stellenbosch and that was very good. All he did was he put in an IUD (intra-uterine device) which was very, very painful when you're pregnant, it was the most excruciatingly painful experience of my life but it wasn't too bad. That didn't work, it can work but after that I had an ultrasound but it missed it by about five millimetres or something, just my luck. Then I went to another doctor and he couldn't help me and in fact he treated me very badly, another one also treated me very badly.

The one, a gynaecologist, even the way he examined me, I wasn't quite kosher with it at all. He did a thorough examination but I don't know if I was just paranoid or very sensitive at that stage. He was very judgmental and the way he examined me was not quite on. It wasn't professional. It was like if you have an abortion or if you're doing something that is against the law you are suddenly just dirt, no matter what. Which is why I think I developed such a problem with going to the doctor after that.

The other doctor had the attitude that this is a problem I just don't want to have anything to do with, get this person out of my surgery immediately.

And then the doctor said I must wait to see if anything was going to happen, nothing happened and the ultrasound proved that nothing was going to happen. I was quite devastated and I didn't know where to go to and eventually there was this other friend of mine - at that stage the only people I spoke to were the people I had spoken to over the phone, they didn't know what to do either at that stage. Obviously the legal way wasn't an option. There was no way I was going to stand around and say I'm mentally unfit as

I'm so obviously a capable person and even the way I was dealing with it was so capable. I looked at myself and said I'm a capable person and there's no way people are going to buy this that I'm not a capable person. I've never had any history or any kind of psychiatric treatment to turn to and say look at me, I've got a problem. Besides I didn't want to. I was very angry that I had to now say I'm psychologically unbalanced or whatever.

f. The abortion itself.

And then this friend of mine said, what is wrong, you've lost about 10kgs in the last week, because I had just stopped eating completely in total trauma. She asked what's going on with you, you seem seriously ill, do you have cancer, you keep going to all these doctors. I said well, I'm pregnant and she said, oh dear. She said she had been going out with this guy for a long time and his father is a gynaecologist, she's going to phone him. So she phoned him and she made an appointment for me.

I walked in, he was actually a top gynaecologist at a top hospital, and he helps women to fall pregnant with artificial insemination, but he's a really top notch doctor and had a larney (smart) surgery. So I walked into his surgery and explained the situation and to this day I don't know why I was so lucky to be treated so well by this man. He had done abortions in England, he was actually a British doctor, before he came to South Africa. He said to me, you really don't need to be treated like this, because I told him and he said, it has been very traumatic for you and I realise that you know you want an abortion but I want you to go home and think about it for 24 hours to make up your mind. This is how it's done but go home and think about it. He gave me antibiotics to take to prevent infection because there is a chance you couldn't have children if things go wrong.

Then he said, there are a few things you have got to know about abortion, your attitude to your boyfriend is going to change, it's going to be difficult, I just have to warn you of this and it's not going to be an easy decision, you're going to have to live with it afterwards, I'm not saying you're going to regret it but you might end up in life not having kids at all and regretting the situation. Just realise that it is a big decision and you've got to think of what this is going to mean. You're desperate now but just think about the big picture.

But it was the first doctor who came along who treated me with such dignity, like I was a person, like I had to right to be treated well by a doctor which I thought I didn't deserve because at that stage I felt like a criminal and I just felt so overwhelmed by this doctor for treating me this way. The next day I went into a clinic, no first I went into his surgery early in the morning and he twisted the IUD just to get that a bit closer because you can have a legal abortion if you've got an IUD inserted and it's ruined the pregnancy because they then can legally take out the IUD because that's why those feminists got me to put it in in the first place because it's like halfway there. Then it's much easier, it's very difficult for a doctor to make an appointment and all of this becomes irrelevant once the pregnancy is established but it's very difficult for a doctor to just do an abortion in a clinic, it's very risky because you have to have general anaesthetic.

Then I went into the clinic but I was kind of dazed. I had to take off all my jewellery, all my clothes and I just remember lying on the table and the doctor said why is your blood pressure so low and all I could think of was because I had gone into the surgery earlier that morning and it was quite a painful experience having the IUD twisted so maybe it was just shock or the way I had reacted. I remember looking at this anaesthetist and I thought this man is being so kind to me, I don't deserve this person to be so nice to me, why is everyone being so understanding and nice. I'm this terrible person, I'm going into this surgery and I shouldn't be treated like this I should be like a piece of meat and be put on the table.

NOTE: The researcher asked the respondent if she felt she needed to be punished.

Yes or just the way people had previously treated me, I thought I don't deserve this. I looked up at the anaesthetist and he was so concerned for my health and he said, your blood pressure is so low and I

thought, don't worry about my blood pressure, just do whatever, I'm nothing. Then they took me and did the operation and I remember coming to afterwards and then I put on my clothes and I walked out. It was a D&C.

g. <u>Your feelings afterwards, immediately; several years later; after having children.</u>

I thought, jeepers, it's finally over, this has now finally happened but it was very, very painful. The worst pain I had ever experienced. I had schedule five painkillers but they still didn't take away this terrible, terrible pain. At home that night with my boyfriend lying next to me, I was in so much pain and I thought this person just can't seem to understand it, he had nothing to give, he was this cold, emotionless person. I thought who have I been going out with for five years, this person is not at all what I thought he was. He was cold, he's got nothing.

Then afterwards I didn't want to go back to work so I phoned and said, look, I'm not coming in anymore, I've resigned. And then my sister found me a waitressing job where she was waitressing. At that stage it was quite difficult because you bleed and bleed and bleed for days and days and days on end. Even if you use super tampons every 30 minutes you have to go and change. It's the womb lining coming loose.

I was eight weeks which is quite a whack of time given all the things I had to do. If it was legal, I could have gone in at three weeks but by that stage (eight weeks) I had morning sickness etc etc. It would have been far less traumatic and quicker and more painless. I mean three weeks, what is three weeks, it's nothing.

I didn't feel anything when I woke up. I felt totally numb. I think it took me six months maybe a year to start feeling anything. I was totally numb, I didn't feel anything anymore. When I started working here which was about three months afterwards, I didn't want any friends, I didn't want to talk to anybody, I didn't want to go out socially. It was like I had nothing to give to the world and nothing to ask from the world. I can't explain it, it was just there. I didn't feel any pain, I didn't feel happiness, I didn't feel anything, I just went from day to day.

To some extent I think I must have felt worthless because when I got to my new job I used to work 12, 14, 16 hours a day and I used to work so hard and people used to think, why are you here so late why are you here all the time. It was like I had to prove to everybody that I wasn't worthless. I had to work twice as hard as anybody else to show that I was somebody. I'd disappointed my parents by doing this, I thought. I had always been the responsible person, the straight A person, I'd always been the person doing the right thing, I've always been the person helping everyone else out and here for once was I fucking up and I hated fucking up, that feeling of, I've made a mistake, I've made a mess, it was terrible.

I can't say I felt worthless because I didn't feel anything directly, all I know is when I look back at that time, I was working like a woman possessed and I had no wish to speak to anybody, to be friendly with anybody at work because I didn't think anybody wanted to speak to me or that anybody wanted to know me or that I wanted to know anybody. My employers must have been glad. I'm glad that I had that. It gave me something to work hard at and to prove that I'm good at something, I can do this well and people seem to have been impressed so I was very keen for that type of positive feedback and it was only after, when I had finally dealt with this whole issue and I didn't feel worthless anymore, and I thought I'd paid back and paid my dues.

Then suddenly I got this disillusion with my job overnight and I realised I'd never done this job because I wanted to, this job's never been for me it's always been to show everybody else that I'm worth something and I'm cool now. That's when suddenly the job became totally unimportant to me and that's why I have resigned because I've dealt with the fact that I've had an abortion to a large extent and, obviously you never completely deal with it, but I don't feel I have to sit at this job and waste my life away anymore within 24 hours a day because I've paid my dues.

The feelings of how I felt about the abortion, I don't think I ever felt anything directly but what could be helpful with counselling is perhaps through dreams. I had had some dreams in which I always stood by

and a crime was being committed or I was a murderer or I was at a party and then someone was being murdered and I didn't stop it. I had the dreams about a year ago (a year after the abortion).

Abortion for many women is such a loss of innocence. It's like an initiation, men go off to the army; they shoot someone and they have to deal with it.

There was some personal growth, but I wouldn't recommend it, but it was empowering because I organised it, I did not want to be an unwed mother so I did it quickly, taking control.

The doctor who helped me, his words are etched in my brain because he showed such kindness and compassion.

But you can't run away from the regret. I regretted it when I saw my fiancé's ex with her baby. Children are beautiful and I would love one.

The medical aspects were expensive. The consultation was R100, the IUD R500 and the ultrasound was R150. The clinic and anaesthetist coast R3 500 but the doctor didn't charge me. I wrote him a note but didn't send it. I wrote that he treated me with such compassion. It restored my faith and it would always redeem people, all the horrible ones, and you were kind. I didn't send it because I thought he wouldn't want to be bothered. In many ways I don't feel important enough.

Even now when I go into a pharmacy I feel small to ask for spermicidal jelly, I insist on seeing a female and get uppity if I don't. I can't bear strange attitudes, people make things so difficult.

I feel like a shit. Why just me? Every time I go to the gynaecologist I just want to cry. People don't make it easy. Maybe I feel the whole world disapproves and silently disapproves. Anyway it was a problem, now I've got it under control and it's fine. Last time the doctor insisted on an internal and it was fine.

I'm not fine about my ex. Just three weeks ago I discussed it with my fiancé because my ex never paid. He said I should ask him to pay. I was tired and insulted and went to sleep separately. The next day he asked what's wrong. I felt so rejected. The rejection is the worst. The next time I contacted my ex, I was very ruthless. I said, this is how much it cost. He wanted to quibble but I wanted him to be responsible and at least be able to redeem some respect in my eyes. He didn't say much but gave me the money. I didn't want to talk to him. Why was I supposed to do it all. Then it was a finished chapter. Take some of the bad feelings of the arsehole paying his own way. I was very unsympathetic to him. I can't extend myself for him anymore.

The abortion made me realise that if a relationship is not strong enough it won't hold up to the trauma of an abortion. With surgical precision, it rid me of that relationship.

I've changed completely, what I want is completely different. What helped me was my sister's got a dog. I didn't have emotional contact with anyone. The basset hound was my baby, I cuddled and nurtured it, I was completely over the top. It slept with me, I cooked it special meals. I just needed to nurture something.

Note: Kim became angry when I inadvertently referred to the baby. She replied: People have no right to assume the foetus is a baby. Mourning is a luxury I don't want to afford myself, it's self indulgent. It doesn't feel right, get real, it's melodramatic. I've been crisp and controlled from the beginning. I don't like to think of myself as a mother. At times I have felt sad and empty but I've never cried. A year later I felt sad but I've never cried. The day after the abortion I spent the day in bed crying and feeling empty. Maybe I am still hard on myself, it will take awhile. I have to live with the choice.

h. Did you have any type of counselling before or afterwards?

Counselling is the best. It is the most beneficial. Just speaking to my friend who had three abortions helped. It also helped talking to the feminists. You need someone to tell you to take morning sickness tablets, the highly practical things. I didn't want to, I wanted to punish myself. Afterwards I did for somebody, I told her what to do, that she wasn't worthless and that she deserved to be treated well. I didn't even know her name. It was difficult to brush your teeth and put on clothes. You're allowed to feel this way, it's normal.

i. What was useful and what was not?

I had a series of hectic dreams at the beginning of the year (a year after the abortion) and the whole thing came to a head when finally I started looking at boys again even though I couldn't imagine kissing them and having anything to do with them but I knew I would, kind of would like to get involved, I thought that I had to, I thought if I don't, I'm never going to get over this, I'm just going to be this old maid and it's going to become more and more difficult to act and change this person I had become. Because I used to be someone that was quite outgoing and quite popular and I liked dressing in sexy ways. My whole dress sense had changed. I couldn't wear anything that showed cleavage or anything. I had become very conservative in my whole dress style.

I thought this wasn't really me and I had to do something to get out and I considered going out with various people but I just couldn't get down to it and eventually, obviously I took this friend, who I had this established relationship with, to start going out. I think my feelings really came to a head when I started going out with him and obviously having sex was one of the reasons and a big other thing was he had an ex-girlfriend who he had been going out with for awhile and she had fallen pregnant, also unplanned, and she'd had the baby, not his baby.

She'd fallen pregnant at the same time I did because I remember him saying that to me and there she had this baby. He was still very good friends with her so we would go and visit her and she had this cute little baby, it was the cutest thing, it was just so sweet. But I hated going there and I got so upset every time I went there because obviously I would compare myself. She made this choice and I made this choice and I'd go there and it would tear me apart and it would be really very, very painful but I forced myself because I almost wanted to almost punish myself but at the same time maybe I knew this was something I had to face and I had to go and see this woman who had a baby. The baby was so cute and I just remember, she was holding the baby and she said, and the baby's name was Joseph, and she said Joseph give Kim a kiss and he did and it felt like I was going to completely crumble away, there was this baby giving me this kiss which was the most terrible feeling. I can't explain it, it was just an awful feeling. Just being confronted with a baby made me face what I had to face.

When I look at her, as much as she loves the baby, she's 20 years old, she waitresses, the baby is taken care of by other people. They live in a room with other people in the house, it's not an ideal situation either, as much as she loves the baby, and I'm sure if I'd had the baby I would have loved the baby in the same way, but that doesn't necessarily mean that was my choice, plus if I look back, she has this baby with this man she has no relationship with that she dislikes intensely, knowing what I know now about this guy, the thought of me having a baby of this man...I want a baby with someone I love, that's going to be there, the baby is part of this guy, somebody that I detest, I wouldn't want to have a child with.

Plus, I think, emotionally I couldn't take care of myself financially, I couldn't take care of myself emotionally. It's never been that much that I made the wrong decision, it was too logical and too right, the decision, it was never am I doing the right thing, am I doing the wrong thing. I've always known that this was the decision, but I've always known there is a price to be paid for this decision. It's not my decision itself that I've questioned, ever. I mean I am very glad I never questioned, it was just this is what you've

got to do, no matter what, this is what's right, so I'm very glad that I had at least that knowledge. Then when I came into contact with this baby, and my fiancé, his best friend, his girlfriend also fell pregnant, so wherever I go with him it was all these babies all the time, babies, babies and I thought no, this was terrible.

I had these dreams, they were three magnificent dreams that helped me a lot. The one was, I was just very, very sad and this elephant came and stuck its trunk through the window where I was sleeping and it just kind of laid its trunk on me, very reassuring. There's this person with this great...why are you doing these terrible things to yourself, and I was crying, and just this trunk on me and I was thinking, if I, in my dreams, can be so kind to myself, why do I have to be so harsh and ugly to myself all the time and subconsciously I had this endearing, sympathetic, empathetic loving feelings. I don't know what it is, if it was my guide or why, someone was saying to me, you don't have to torture yourself like this, it's OK.

And then I had this other magnificent dream, I was on a bicycle and I saw these two people on a bicycle, it was two little spots and it was this open wide landscape and they were travelling towards each other and they got bigger and bigger and bigger but obviously were coming out of opposite directions. As I came closer I saw it was this older woman and this little kid who was about 10 years old and when I looked again I realised it was my baby, my child, it had grown up and was 10 years old, because I recognised myself in her and we just looked at each other and jumped into each other's arms and I said, we've found each other, and she was so glad and she said, I've found you, and I said, I've found you, and we hugged each other and kissed each other and we were so glad, it was like this part of me had been found. I just looked at her and there was this woman, this elderly woman standing next to her and she looked down at us and she looked with so much love and compassion, something that surprised me, my dreams have always had so much love and compassion, and she was now obviously the kid's mother. This child, I'm not a mother, this is a mother, this child belongs, you could see this was her child and this was her mother and they belonged with each other. You love each other and you're part of each other but I'm like, look at me, I'm like this teenager on a bicycle. And then they took off in the opposite direction and I took off in the opposite direction and I just had this knowledge that this child was, it was like, it was the right decision and she was with someone that loved her. It was very sympathetic of me that had all this love and compassion for me as well.

And then I had this third, my last dream was, we all got onto this train, it was this kind of old Russian train and everybody from my work was there and everybody sitting around, and as I got onto the train, I noticed this woman, she was this Russian peasant type woman, she was like a cleaning lady on the train and she was holding this parcel. The train went off and we travelled through this landscape, we travelled such a long time, first I saw this woman in her wedding dress and she was swirling this wedding dress standing in front of a mirror and doing a fitting obviously, and then we drove down a beach and I saw these waves and these waves were breaking against these amethyst rocks. Amethyst to me is the most beautiful thing in the world, it's my most favourite thing. I just thought it was this most beautiful thing, these waves crashing against these purple rocks, and then I saw this lady and everything changed and I saw this lady in the train and my focus became the train and I realised that this child she was holding was like a vegetable, it was like this retarded thing with no brain and then the train went slowly, it went around a bend and then she opened the train door and she took the baby and she put it on the side on the tracks, but while she was doing it she had the saddest most strangest look on her face, like she really, really loved this baby but..., and then she just had to put down this baby on the side of the tracks because she realised it was a vegetable, it was dead, it was nothing and I just felt so sad for her because she looked so terribly, terribly sad. Then she closed the train, it was like a goods train and the train went on and I think that was also now obviously a very good dream.

j. What would have helped?

Legalising abortion is not going to change anything except that you won't feel like a criminal trying to arrange it but society's attitudes are not going to change.

I think group counselling would be the best because with abortion, it has to be kept inside, festering. People don't want you to heal.

k. Who else knew/did you talk to?

I told my mother at the time because we were very, very close and because this was going to be such an important thing, I didn't want it to come between us and although she was very supportive she was so distraught about what I was going through she couldn't really offer any support. Even though she would have liked to, it was just too terrible for her that her child was going through this so it was better that it was somebody that was separate. She supported my decision and said do whatever you have to, if you need money, phone, do you want me to come up and I said no, there's not really anything you can do which I think she still feels guilty about, the fact that she didn't get on a plane but anyway I knew there was nothing she could do.

Afterwards, I used to be angry and tell people because I feel if people love me they must know and accept me, if not they must scoot.

l. Did you have any religious or moral views on abortion before the termination or after and did these change?

I was brought up very religiously and I'm religious in the sense that I believe in souls. That kind of religion, not a structured, full on. I grew up Dutch Reformed which is problematic because it does give you very strong...(the respondent possibly meant views or beliefs).

m. Did your feelings about having children change after the abortion?

Out of all of it, I'd like children and I do love children. It would be the most important thing to me. I'd love it more than anything else. I want it to be the most beautiful experience, magical, everything that it wasn't. Pregnant women look so beautiful. For two years, I've thought about being a mother. I've had an inkling and I can see myself as a mother. I wouldn't be perfect but it's not an unnatural image.

Note: A friend of Kim's who proofread this with her permission was surprised at this statement because she had told her with certainty that she did not want children but would adopt.

n. What would you say to someone seeking an abortion?

This question was not answered but Kim had already provided information to someone seeking an abortion.

o. Would you have another abortion?

I don't think I could have another abortion - it was very harmful to me. I had to learn how to be sexual again. I couldn't even kiss, I had to learn how to feel, it was horrible.

NOTE: When I spoke to Kim the following day she said she was feeling very down as a result of having spoken about it. She did not want to talk about it anymore.

ON WHAT DESPAIR
THE PAIN I BEAR
AS LIGHTNING FLASHES
THRO' MY HEART
AND THUNDER ECHOES
IN MY MIND

I AIMLESSLY ROAM
LOST AND ALONE
AS MY EYES NO LONGER FOCUS
AND MY EARS REMAIN DEAF
TO THE PIERCING SCREAMS
OF MY SOUL

ANOTHER DAY DAWNS BRIGHT
VICTORIOUS OVER THE NIGHT
AND I WANT TO SPIT
AT THE SUN FOR SHINING
WHEN MY DAY LOOMS AHEAD
GREY, DARK AND FORLORN

MY LIGHT HAS GONE AWAY
AND THO' I KNOW THAT IT MAY
ONE DAY SHINE FOR ME AGAIN
FOR NOW I AM CONTENT
TO HIDE ALONE
IN MY GLOOM

CLOSETED I'LL REMAIN...
BEHIND DRAWN CURTAINS
AND LOCKED DOORS

FOR, OUTSIDE
LIVES THE WORLD
AND I CANNOT BE
A PART OF IT
RIGHT NOW

---

don't try to build a future while you're still living in yesterday's broken dreams ... for destruction is difficult to re-erect.

Yesterday's future is tomorrow's past.

Unless you have the eyes of compassion and sensitivity with which to see into my soul you shall always remain blind to the real me.

I AM I... BUT HOW I WISH I COULD BE ME!

May the beauty of love forever adorn you in the serenity

You are you and I am I
But together we share
as one side

I SHRUG INTO MY SHROUD OF EMPTINESS
AND MY SOUL SCREAMS FROM WITHIN
MY PAIN IS ETCHED DEEP INTO THE CORE OF ME
HIDDEN FROM PRYING EYES
AND THE TEARS I CRY ARE DRY...
MY STRENGTH MUST REMAIN FOR
THERE ARE TOO MANY WHO NEED ME
TO HELP THEM THROUGH THE TORMENT
WITHIN THEIR SOULS...
IF THEY KNEW MY OWN WEAKNESS
I FEAR THEY'LL REJECT ME FOR
THEIR FRIENDSHIP EXISTS ONLY
AS FAR AS THEIR NEED OF ME

IF ONLY ONCE THEY COULD LOOK
BENEATH MY SMILE
AND DISSECT MY STRENGTH...
THEY WOULD SEE THE SCARS OF
MY PAIN... ETCHED DEEPLY AND FOREVER

EACH SCAR HAS A STORY
AND EACH STORY A LESSON LEARNT
AND YET I CAN'T AFFORD THE LUXURY OF TEARS...
FOR THEY MAY CLEANSE MY PAIN AND LEAVE ME
STRIPPED OF MY DEFENCES AND I WOULD
BE VULNERABLE AGAIN...

BUT PLEASE DON'T PITY, NOR CRY FOR ME
JUST PLEASE... BE MY FRIEND

———oOo———

IN THE HAZY SHADOW OF
MY SOLITUDE
I TRY TO HIDE FROM THE
PAINS OF MY EXISTANCE...
I SEARCH THE DEEPEST
CREVICES OF MY MIND
FOR AN ANAESTHETIC
TO TRANQUILISE THE
AGONISING MEMORIES OF
MY DEFEATS AND HUMILIATIONS...
I CONSTANTLY STRIVE FOR
THE SERENITY OF ACCEPTANCE
WHEN THE TIDES OF MY TEARS
FAIL TO WASH AWAY THE
DISILLUSIONS OF
MY DREAMS

I CRY BEHIND
MY LAUGHTER
AND FROWN BEHIND
MY SMILE...
I AM HARD... AND I AM TOUGH...
BUT LOOK A LITTLE DEEPER...
FOR ONLY WITH THE EYES
WITH WHICH TO
PENETRATE A SOUL
WILL YOU EVER BE ABLE
TO SEE MY VULNERABILITIES...
MY INADEQUACIES... MY WEAKNESSES
AND MY SENSITIVITIES...
YES... ONLY THEN

PTO

WILL YOU BE ABLE

TO SEE THROUGH

TO THE CORE OF

THE REAL

ME

SUNSHINE AND LAUGHTER

MEMORIES RECOLLECTED YESTERDAY

SEEING YOU AGAIN

REACHING OUT AND TOUCHING

LIKE WE'D NEVER DONE BEFORE

CLIMBING TREES... THROWING FRISBEES

SIPPING CHAMPAGNE

BUT WE BOTH KNEW OUR TIME WAS BRIEF

NOW WE'RE APART AGAIN

FOR SO LONG I HAD WAITED

FOR THAT MOMENT

DREAMED ABOUT BEING

LOST IN YOUR ARMS

TEN LONGING YEARS OF WAITING.

JUST TO SEE YOUR FACE

THEN YESTERDAY YOU MADE

MY DREAMS COME TRUE

TODAY I FEEL THE LONELINESS

.. EVEN MORE THAN EVER BEFORE

I FEEL IT EMBRACING ME IN

IT'S ARMS OF ICE...

TIGHTENING IT'S HOLD...

... SQUEEZING.. SQUEEZING...

I CRY OUT IN TORMENT BUT...

THERE IS NO-ONE TO TURN TO

NO-ONE TO HELP ME

NO PLACE TO GO

I BREAK FREE AND START RUNNING

BUT IT'S FOLLOWING ME

AND I'M LOSING MY MIND

I CANNOT OUTRUN IT...

HELP ME PLEASE... FOR GOD'S SAKE

SOMEBODY ... HELP ME...

I WALK ALONG THE LONELY, DESERTED

STREETS OF UNHAPPINESS

AND KEEP SEARCHING FOR

SOMEONE TO TALK TO...

SOMEONE TO SHARE MY THOUGHTS WITH...

SEARCHING FOR YOU

I TURN 'ROUND AND 'ROUND

AND STRAIN MY EYES

FOR THE SIGHT OF YOU...

BUT ALL I HAVE ARE VISIONS OF YOUR FACE ON MY MEMORY

AND THE ECHO OF YOUR VOICE CARRIED SOFTLY TO ME

ON THE WINGS OF THE WIND...

WHERE ARE YOU? .... WHY ARE WE APART?

FOR WHAT PURPOSE THE LIVING
FOR WHAT REASON THE PAIN
WHY DO I LET MYSELF LOVE
WHEN THERE IS NO GAIN

HOW STUPID I'VE BEEN
WHEN I KNOW FROM THE PAST
THAT MY HEART SHOULD STAY HIDDEN
FOR NOTHING WILL LAST

NO MORE WILL I EVER
LET ANYONE TRY
TO BREAK DOWN MY DEFENCES
AND LEAVE ME TO CRY

THE TEARS OF DESTRUCTION
THAT RIP ME APART
I'LL LOCK AWAY FOREVER
MY EMOTIONS... AND MY HEART.

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