

**The Use of a Stress and Coping Model to Understand Women's Experiences with
Abortion**

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(ABSTRACT)

Six women participated in a qualitative study to understand women's experiences with abortion. The women ranged in age from 52 to 26, and were at least five years post-abortion. A questionnaire was developed using a stress and coping model as a guide to answer the following: relevant primary and reappraisal processes; problem-focused and emotion-focused coping strategies; resources; and personal and environmental constraints. The results give the women's individual experiences as well as the themes that were consistent for the participants. The women all appraised the situation of an unplanned pregnancy as stressful. All of the participants viewed having the child as a threat to their education, career, or relationship with family. Although all of the women thought some part of the procedure was more stressful than they had anticipated, all found ways to cope with differing levels of stress. The women saw their friends, family, ob-gyn physicians, priest, and clinic staff as resources during the experience. The women most often reported that religious beliefs constrained their abilities to cope. They also reported a lack of information about the abortion procedure and possible physical and emotional effects as environmental constraints. Overall, all but one participant would make the same decision, and all viewed themselves as coping well with a stressful life event.

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CHAPTER ONE

INTRODUCTION

The Problem and Its Setting

It has been estimated that one in five women in the United States will have an abortion during her lifetime (Mueller & Major, 1989). This procedure affects the lives of substantial numbers of women, and if we add the effects on partners, family, or other social supports, a substantial number of people overall. The issue of abortion is further impacted by the differing moral, ethical, and religious perspectives that affect how abortion is perceived (Adler, 1992). This perception can further complicate the decision and stress involved in the procedure. For example, it is unheard of to arrive to the hospital for a medical procedure and have picketers yelling slanderous statements at a patient. The intensity surrounding the moral and emotional climate of selective abortion can make scientific evidence difficult to collect.

In addition to the climate that surrounds abortion, there is vastly conflicting research on the psychological affects of having an abortion ranging from no effects to severe trauma. An article written by Bagarozzi (1994) identifies post traumatic stress reactions in a sample of 18 women who have undergone abortions. And Kesselman (1990) goes as far to say that grief therapy must be a part of counseling for every abortion. There has also been support for the idea that abortion does not produce significant stress for most women. In 1989, the US surgeon general, after a review of research on the psychological effects of abortion, concluded that although abortion can be overwhelming to a given individual, the potential for psychological problems is minuscule from a public health perspective (Tentoni, 1995).

Little research has been done to include the voices of women sharing their experiences. This study will interview women who have had elective abortions to find out their emotional responses, as well as the resources, strengths, and strategies they used to cope with the decision process, procedure, and time period after termination. A stress and coping theoretical framework will be used to guide this qualitative study.

Rationale for the Study

As many as 1.5 million pregnancies end in abortion each year in the United States and research related to how these women have responded and coped is limited (Butler, 1996). Coping is an appropriate place to focus attention because the best available studies on psychological responses following legal, nonrestrictive abortion in the U.S. suggest that severe negative reactions are infrequent. Therefore, women must be doing something to cope with their decisions. Much of the research on abortion is primarily concerned with discovering the antecedents or causal variables of an adaptational outcome. Research seeks the causes of these outcomes in existing environmental or stable individual factors. Many articles, similar to that by Gameau (1993), are focused on identification of factors that will lead to negative post abortion reactions. This style of research is helpful when dealing with a system in which there is one powerful causal factor, but does not elicit the depth of information in cases where multiple variables mediate the response outcome.

It would be helpful for clinicians and others to see how women have coped and responded to having an abortion. The broader circumstances that affect the way women respond are often missing from quantitative research. Butler (1996) emphasizes the importance of understanding women's experiences, and goes on to express concern that

in abortion research the voices of women are missing. While most previous research looks at causes of reactions to abortion, this study will be using a relational perspective to guide the research process. This model views the person and the environment in a dynamic, mutually reciprocal, bi-directional relationship (Lazarus & Folkman, 1984). In other words, instead of focusing on antecedent variables as possible causes of outcome, the process by which variables affect the outcome can be examined.

The resources available to this group of women are largely unknown. It is not clear what kinds of resources are helpful in the coping process. Not only is it not clear what types of resources are accessed, but little is known about how satisfied the women were with their chosen support.

Self of the Therapist

I was born in a suburb of Washington, D.C., where I have lived all of my life. I attended private school until age 11, when my parents enrolled me in Catholic school. I continued to attend Catholic schools until I left home to go to college. Although the Catholic teaching is vehemently opposed to abortion, I myself never adopted this viewpoint. I was never faced with the situation that I had to make a decision about the outcome of a pregnancy, but before being married, abortion would have been an option I would consider. I have emotionally supported several friends after they had chosen to have abortions. If I had to categorize my beliefs, I would say I was pro-choice, because I feel that every woman should be given a choice if faced with an unwanted pregnancy.

Theoretical Framework

Traditional research on stress has focused on antecedent-consequent or stimulus-response models (Lazarus & Folkman, 1984). Lazarus and Cohen defined stress stimuli

in 1977 as major changes, which could either affect large or small numbers of persons, and daily hassles. Stress has also been defined by medicine and biology in response terms, describing the person or animal in a state of stress, reacting with stress, being disrupted, distress, and so on. One obvious shortcoming to both of these definitions is that it is not an either/or question, but rather a process. It is too simplistic to pretend that there is an objective way to define stress at the environmental level without taking into account the characteristics of the individual. To gain more complex information, a relational perspective is helpful to deduce the intricate reaction pattern and its adaptational outcomes.

The definition of psychological stress which will be used for this investigation is, “a particular relationship between the person and environment that is appraised by the individual as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p. 19). Two critical processes that mediate the person-environment relationship must be defined to gain a clear understanding of the theoretical basis for this study: cognitive appraisal and coping. “Cognitive appraisal” is the evaluative process that determines why and to what extent a particular transaction or series of transactions between the person and environment is stressful. Coping is the process through which the individual manages the demands of the person-environment relationship that are appraised as stressful and the emotions they generate” (Lazarus & Folkman, 1984, p. 19).

Although demands and pressures produce stress for most people, individual and group differences can be identified in regards to one’s response and degree of stress experienced (Lazarus & Folkman, 1984). Individual differences are most likely a result

of one's sensitivity and vulnerability to certain types of happenings, as well as one's interpretations and reactions. To understand how differences among individual's reactions vary in similar conditions, one must examine the cognitive processes that intercede between the encounter and the reaction, and the factors that affect this mediation. Cognitive appraisal processes of some sort mediate reactions and are necessary to understand the reciprocal relationship of individual reactions. Cognitive appraisal helps us to understand the reciprocal relationship between a person and their characteristics such as values, commitments, and styles of perceiving and thinking. How a person interprets an event and gives it meaning affects behavioral and emotional responses.

Cognitive appraisal is a continuous process as one interprets an event and its many dimensions and decides its importance for their well-being (Lazarus & Folkman, 1984). Primary appraisal is categorized as a judgement regarding an event that one encounters as irrelevant, benign-positive, or stressful. For an event to be interpreted as irrelevant, the individual must have no concern for possible outcomes, and nothing is determined to be gained or lost in the process. A situation is determined to be benign-positive if the outcome is interpreted as positive or has the potential to continue or strengthen well-being. A stressful appraisal is thought of as a harm/loss, threat, or challenge. A harm/loss is concluded when some damage to the person has already happened. The anticipation of harm or losses, which would have a negative effect on the future and create fear and anxiety is labeled a threat. Challenge concentrates on possible gains or growth opportunities and pulls one to rally coping efforts which results in positive emotions such as eagerness, excitement and exhilaration.

Secondary appraisal is defined as “a complex evaluative process that takes into account which coping options are available, the likelihood that a given coping option will accomplish what it is supposed to, the likelihood that one can apply a particular strategy or set of strategies effectively” (Lazarus & Folkman, 1984, p. 53). This process takes place simultaneously within the context of other internal and/or external demands and constraints. Secondary appraisals of coping options and primary appraisals of what is at risk, have reciprocal influence on determining how much stress will be experienced and the strength, content, or quality of the emotional reaction. The way a person interprets an event strongly affects the coping process and how the person responds emotionally. This perspective sees cognitive appraisal as essential in mediating subsequent thoughts, feelings, and actions and is necessary to understanding individual differences.

Coping can be seen as continuously changing cognitive and behavioral efforts to deal with external and/or internal demands (Lazarus & Folkman, 1984). Coping is a process that results from constant appraisals and reappraisals of the changing person-environment relationship. Changes in this relationship may be because of coping efforts to change the environment, or coping inward, which would be to change the meaning of the event or increase understanding. Shifts may also be the result of changes in the environment that have nothing to do with the person and his or her coping activity. Regardless of the source of this shift, any change in the person-environment relationship will result in a reevaluation in what is happening, its importance, and what can be done. Thus, the coping process is continuously mediated by cognitive reappraisals, which are intervening in the coping process because they follow and modify an earlier appraisal.

There are two forms of coping: emotion-focused coping and problem-focused coping, both are defined as all efforts to manage or alter the problem with the environment causing distress, without regard to outcome (Lazarus & Folkman, 1984). One type of emotion-focused coping uses avoidance, minimization, distancing, selective attention, positive comparison, and getting positive value from negative events to decrease distress. Another type of tactic tries to increase emotional distress because some individuals need to experience their distress through self-blame or other forms of self-punishment to get relief. In other instances, individuals intentionally increase their emotional distress in order to gain energy or clarity for action. And finally, certain cognitive forms of emotionally-focused coping can also reduce threat by changing the meaning of the situation without affecting the situation.

The problem-focused forms of coping are defined as “efforts often directed at defining the problem, generating alternative solutions, weighing alternatives in terms of costs and benefits, choosing among them, and acting” (Lazarus & Folkman, 1984, p. 156). However, problem-focused coping has more than one purpose because some strategies are focused on changing the environment, while other strategies are focused inward. Problem and emotion-focused coping influence each other throughout a stressful encounter; they have the ability to both help and hinder each other in the coping process.

The way a person copes is influenced by his or her resources, which include health and energy; existential beliefs, or general beliefs about control; commitments, which have a motivational property that can help continue coping efforts; problem-solving skills; social skills; social support; and material resources (Lazarus & Folkman, 1984). Coping is also determined by constraints that hamper the use of resources.

Personal constraints might include internalized cultural or familial norms, values, or beliefs that dictate certain ways of behaving, and also psychological deficits.

Environmental constraints include demands that compete for the same resources, and agencies or institutions that hinder coping efforts. High levels of biological threat such as hunger, thirst, injury, illness, or physical injury also prevent a person from using coping resources effectively. This theoretical perspective served as a guide to questions asked and for interpretation of interviews.

Purpose of the Study

The purpose of this study is to increase our understanding of the appraisals, coping strategies, and resources which women utilize in making the decision to terminate a pregnancy, during, and after the procedure as well looking at the impact on the lives if any. Semi-structured interviews were be conducted with each of the participants in which they were asked to recall internal thought processes which affected their decision making as well as coping after the procedure. The data coded from the interviews was analyzed to:

- (1) Discover and describe the relevant primary and reappraisal processes the women went through
- (2) Describe the problem-focused and/or emotion-focused coping strategies
- (3) Describe the resources the participants felt were helpful
- (4) Identify any personal or environmental constraints to coping
- (5) Draw conclusions and comment on differences, if any

CHAPTER TWO

LITERATURE REVIEW

This section will begin by discussing the history of abortion in the United States. The next section will focus on the demographic factors of age, number of children, religion, and length of pregnancy, and religion which have all been previously studied as risk factors of negative psychological reactions to abortion. The decision making processes which are involved in abortion are discussed, followed by a short section of how ethnicity affects these processes. The chapter concludes with a review of the literature on how appraisals, attributions, self-efficacy, and coping influence women who have abortions.

History of Abortion in the United States

Abortion is one of the oldest, but most controversial of current medical practices which still exists today (Adler, 1979). Similarly to other medical practices, it has been regulated to prevent undue harm to patients. But unlike other medical procedures, limitations have also been implemented due to moral, religious, and political concerns. Abortion can be not only a medical procedure, but also a socially stigmatizing and stressful. Therefore, research has been done on the psychological as well as social aspects of the procedure.

The legal and social status of abortion has undergone many changes throughout history (Adler, 1979). At the onset of the 19th century there were no legal statutes dealing with abortion. By the close of the century, there were restrictive laws in each jurisdiction. Abortions in the United States prior to 1973 were mostly clandestine procedures (Adler, David, Major, Roth, Russo, Wyatt, 1992). Under some state laws

before 1973, psychological issues allowed women access to legal abortion. Physicians as a result of pressure from their upper and middle class patients, agreed to turn to psychiatrists to certify the need for access to safe abortions. Hospitals had rules that allowed abortion if the woman could provide letters from one or two psychiatrists stating it was necessary to prevent suicide. Determining the numbers of abortions in the U.S. before 1973 is difficult because most were illegal procedures. Estimates range from a low of 200,000 to a high of 1,200,000 each year.

A 1973 Supreme Court decision in *Roe v. Wade* declared that a woman has a constitutionally protected right to obtain an abortion, which is derived from her right to privacy (Adler, 1979). The court decided that during the first trimester, the abortion decision is protected by the right of privacy and rests with a woman and her physician. Later in pregnancy, the state “may regulate the abortion procedure in ways that are reasonably related to the preservation and protection of maternal health” (Adler et al. 1992). In the third trimester, abortion is limited except in the case where it is necessary to preserve the life or health of the woman. Since its legalization, organized opposition to abortion has become a national movement, as well as the focus of research of its psychological impact.

Although the term abortion is often used to describe a single procedure, there are varying medical procedures, which terminate pregnancy (Adler, 1979). They range from dilation and evacuation (d and e), which takes about 15 minutes, and can be performed without anesthesia to saline abortion in which saline is injected into the amniotic sac, causing the fetus to abort within 24 hours. Abortions are also performed in a wide range of settings including: hospitals, clinics, physician’s offices, and “back alleys.” Since its

legalization in 1973, the number of abortions performed in hospitals has dropped about 40%, and currently the majority of abortions are performed in nonhospital clinics (Adler et al., 1992). It has also been estimated that 21% of American women of childbearing age have had abortions.

Demographic Variables

A number of demographic variables have been studied that impact how a woman responds to the experience of having an abortion. These factors include age, number of children, religion, and length of pregnancy.

Age and Number of Children

When the available literature is examined, the majority of studies have found that women under the age of 19, as well as those who do not have children are relatively more likely to experience negative responses when compared to older women who have already given birth.

As early as 1975, Adler interviewed women in a non-profit counseling agency in Boston. Approximately 60% of the women who were approached agreed to participate. One hundred women were interviewed, and 95 had abortions, but only 70 returned for the second interview two to three months post-abortion. Although the participants that returned were older on the average and less likely to be Catholic than the non-returnees, they did not differ on other variables under investigation. From her data, Adler concluded that age was inversely related to the intensity that negative emotions were experienced.

In a 1983 study, Hendricks-Matthews found similar results by using the medical charts and termination sheets of 1,891 women who had abortions performed at North

Carolina Memorial Hospital in 1980 and 1981. She concluded that the nulliparity as well as having an abortion younger than 18 were significantly related to an increased risk for a negative traumatic reaction.

In support of Hendricks-Matthews findings, Payne, Kravitz, Notman, and Anderson (1976) studied 102 patients referred to the Beth Israel Hospital for a psychiatric evaluation which, as well as consent of the hospital committee, was required before the procedure was scheduled. The subjects were given a Minnesota Multiphasic Personality Inventory (MMPI), Profile of Mood States (POMS), Symptom Rating Scale (SRS), and were interviewed as well as observed by a psychiatrist on the research team. Interviews were conducted within 24 hours in the hospital, at 6 weeks post-abortion, and at 6 months post-abortion. The POMS and SRS were administered at each interview, and the MMPI at the 6 month follow-up. They found that the women who had previously borne children, experienced significantly less anxiety ($P=.018$), depression ($P=.042$), guilt ($P<.001$), and shame ($P=.049$) than did the women who had never had a child.

Religion

Religiosity and religious beliefs that abortion is wrong are positively correlated with negative reactions to abortion. In 1972, Osofsky and Osofsky studied 380 women who had abortions between the opening of a facility at the State University Hospital in Syracuse, New York and January 1, 1971. The patients ranged in age from 12 to 44. The mean patient age was 23.5, and 43.9 % of the sample were Catholic. Psychological interviews were conducted with 250 of the women shortly after the abortion, and only 8.2% of them reported considerable amount of guilt. The Catholic women were found to have experienced somewhat more guilt, and had more difficulty in making the decision as

well as experiencing the procedure. Payne, Kravitz, Notman, and Anderson (1976) also found similar results in their study done at Beth Israel Hospital. At each evaluation point, Catholics were rated as experiencing more guilt and shame than did Protestants, but Protestants more than Jews.

In a 1975 study, Adler interviewed women in a non-profit counseling agency in Boston, which acted as a referral agency for women with problem pregnancies. In this agency 97% of the clients decide to terminate their pregnancies. Approximately 60% of the women who were approached agreed to participate, and this resulted in 100 women being interviewed. Unfortunately the women who did not return for the follow-up interview were more likely to be Catholic, but she still found a moderate correlation between Catholicism and guilt and shame, but found a much stronger correlation between religiosity and guilt and shame. She concluded that it may not be religious teachings, but the degree to which a woman has internalized these beliefs that matters. She suggested that unless a Catholic woman has contact with the church community, she might not be any more likely than a non-Catholic to experience social disapproval.

Length of Pregnancy

Osofsky and Osofsky (1973) found that of the 114 women that they examined at Temple University Hospital, 10 percent of the women who aborted during the second trimester felt guilty and 12 percent felt depressed, as compared to only 2 percent of the women who had first trimester abortions. Brewer found similar results in 1978 when he interviewed 25 women 3 months post-abortion having abortions in 2 clinics in Britain. All women had the procedure after 20 weeks of pregnancy. Five of the women felt depressed as a result of the abortion, and five women also reported that the fetal

movements made their decisions more difficult. The article concluded that the rate of depression was higher in this group than in the general findings of post-abortion depression, and that length of pregnancy may be associated with more distress.

Blumberg, Golbus, and Hanson (1975) conducted psychiatric interviews at the University of California at San Francisco with 13 families in which results were positive for genetic defects, and an abortion was performed. They suggested that second trimester abortions may be experienced as more traumatic, particularly if the woman has felt fetal movement because she may be more likely to view the fetus as a “future child.” Therefore, they felt that abortion at this stage is more likely to be mourned as a loss.

It has also been suggested by Kaltraider et al. (1979) after studying 250 women, that the procedures used in second trimester abortions, particularly induction of labor and expulsion of the fetus (intrauterine instillation), saline, or prostaglandin induction involve a more prolonged and painful experiences than those used in first trimester abortions. These negative results from second trimester procedures may be associated with greater post-abortion distress. The length of pregnancy may also be related to ambivalence about the decision, which will be examined in the next section which discusses the decision-making process.

Decision Process

Since nearly half of all pregnancies are unintended, many women have to make decisions whether to continue or terminate the pregnancy. About half of these unintended pregnancies result in abortion. The decision to continue or abort a pregnancy depends on many different factors, and can affect individuals very differently.

In 1973 Osofsky et al. and in 1978, Bracken also suggested that most women do not have difficulty with the decision to abort, but that this decision making becomes more difficult during the second trimester. Osofsky, Osofsky, and Rajan (1973) examined women's experiences at the Temple University Health Sciences Center in Philadelphia. This program has been made available to low-income patients throughout the community. At the time the article was written, 114 of the 300 planned for the study had participated. The women were matched for age, parity, race, and trimester of pregnancy. Significant differences were found between the first and second trimester groups. Five percent of the first trimester, and 28% of the second trimester patients needed a longer time before they were aware of and confirmed the fact that they were pregnant. Eleven percent of the first, and 15% of the second trimester reported difficulty finding a facility that would perform the abortion. Of the first trimester patients, 12% reported being scared when they learned about the pregnancy, versus 25% of the second trimester patients; 12% reported the decision to abort as difficult compared to 51% during the second trimester; and 7% of first trimester women reported initial indecision versus 36% of the second trimester participants. One interesting finding was that although the groups varied in many other ways, almost all of the women felt that they had made the right decision, and only 4% of individuals in both the first and second trimester groups had any uncertainty about their decision.

In 1972, Osofsky and Osofsky also examined 250 reports from patients that were admitted through the outpatient clinic at the State University Hospital in Syracuse, New York. Of this sample, 52.5 % reported that the decision to obtain the abortion was not a difficult one; 19.5% reported moderate difficulty; and 28% considerable difficulty.

Difficulty was reported by 32.6% due to their desire for the child, 20.1 because of their psychological discomfort with the decision, and 3.3% due to fears of physical discomfort. The results also showed that the most frequently reported reasons for obtaining an abortion were centered on finances and unmarried status.

It has also been concluded that those women who make a decision before a pregnancy occurs, or who report little difficulty making the decision show less negative post-abortion responses (Cohan, Dunkel-Schetter & Lydon, 1993). Forty-four women who sought a pregnancy test at a private women's health clinic in southern California were asked to participate. Eleven were dropped from the analyses, 2 miscarried, 1 was still undecided about the outcome of the pregnancy at the final assessment, and 8 either withdrew or could not be reached. For the purpose of this study, women were divided into three groups: those who were initially undecided and later aborted, women who initially decided to abort and followed through, and women who initially decided to carry and did so. As expected, the undecided aborters experienced significantly more decision-making stress than did decided carriers, and decisional stress for decided aborters fell between undecided aborters and decided carriers. Although overall, all women were satisfied with their decisions to either carry or abort the pregnancy. The mean values on a 5-point scale from not at all (1) to extremely (5) showed that women who aborted were quite satisfied, while women who carried were extremely satisfied. It was also found that women who carried out their pregnancies were marginally more satisfied with their decision one month after a positive pregnancy test than those who aborted. Of the 33 who were interviewed, 78 percent reported that they had already made a decision about the outcome of the pregnancy before the pregnancy test was given. All the women

except one carried out their original decisions, and indicated that they felt it was very important that they were able to make a choice about their pregnancy.

Studies have also found that women who felt ambivalence and coercion were more likely to be dissatisfied and have poorer emotional responses. A study in 1977 by Belsey, Greer, Lal, Lewis, and Beard examined 326 women who had been referred to the King's College Hospital for outpatient termination of first trimester pregnancies. Three months after the procedure, nine women in the sample regretted the abortion, 55 stated ambivalent feelings, and the remaining 262 reported that they were "glad" or "pleased" that the pregnancy had been terminated. Ambivalence was found to be a predictor of adjustment. Over half the women (60%) who reported considerable ambivalence before the procedure remained ambivalent 3 months later, compared to 87% of the women who had been definite in their desire to have the abortion were pleased it had been performed. The study also found that ambivalence proved to be a highly significant discriminator of the women who expressed guilt. Almost half of the women who expressed "considerable" ambivalence beforehand suffered from continuing guilt, compared with only 8% of those having positive attitudes toward the abortion. While based on his clinical observations, Friedman (1977) concluded that emotional trauma was more likely if the abortion was under coercion or if the pregnant woman felt like the decision was not her own.

Although age was specifically addressed in an earlier section, the three research studies that follow show that age also affects a woman's decision-making process.

In a 1983 study, Hendricks-Matthews used the medical charts and termination sheets of 1,891 women who had abortions performed at North Carolina Memorial

Hospital in 1980 and 1981. Her data indicated that women below 18 years of age have a 20% greater chance for waiting to seek an abortion than women who are older than 18. This puts them at a disadvantage especially if they were not aware of the more difficult procedure for the abortion during the second trimester.

Eisen and Zellman (1984) surveyed 297 premaritally pregnant Caucasian and Mexican-American adolescents whose ages ranged from 13 to 19 years who received pregnancy counseling, pregnancy termination, or prenatal services at a county clinic. These teenagers whose average age was 17, were reinterviewed six months after their abortion or decision to deliver to assess post-decision satisfaction. Eighty-two percent said that they would make the same decision again regardless of whether they aborted or delivered. There were no significant effects of age on satisfaction.

Robbins (1984) conducted a similar study in which he studied women 15 to 23 who were unmarried, pregnant for the first time, and presented themselves for either delivery or abortion at a large teaching hospital in the southern United States from 1972 to 1975. At the one-year follow-up interview, half of the aborters indicated “some” or “deep” regret, while only 16.7% of deliverers experienced “little,” “some,” or “deep” regret. During this interview the women were also asked if they would make the same decisions if presented with a similar situation. Forty-eight percent of the aborters said they would reconsider their decisions, compared with 40% of the deliverers. This study seems to contradict most findings, but the sample also had a two-thirds attrition rate. Also this study was conducted earlier than most of the other studies, and results may reflect attitudes more prevalent at that time.

Ethnicity

Ethnicity may also be a factor in the decision making process. In studying 148 first and 153 second trimester abortion of which 113 were black at Yale-New Haven Hospital, Bracken and Kasl (1977) found that the black women delay longer at each stage of decision-making. They measured the time from the first missed period to suspicion of pregnancy, suspicion of pregnancy to seeing a physician, suspicion to deciding to abort, and weeks to locate the clinic. The greatest difference was the time before suspecting pregnancy, with means of 5.4 weeks for black women versus 3.9 for Caucasian participants.

In 1972, Bracken and Swigar reviewed the clinic records of 443 applicants who had received abortions at the Yale-New Haven Hospital. While only 29.6 % of the sample were Black, differences were found between White and Spanish, which were grouped together, versus Black applicants. Half of the black women sought an abortion after the tenth week of pregnancy versus 1/3 of the rest of the sample. They also found that among Black women with more than four children, abortions were likely to be done at a later stage in the pregnancy.

Appraisals, Attributions, Self-Efficacy, and Coping

In addition to decision making, appraisals are very important because they go beyond the decision making to understand how one interprets an event, or understands what is happening in different situations. One study focused on how the women appraised the situation of having an abortion, which affected how stressful she regarded the event (Major, Richards, Cooper, Cozzarelli, Zubek, 1998). They studied women who had a first trimester abortion at three freestanding abortion clinics in 1993 in Buffalo,

New York. Of the 1,749 who had abortions, 1,177 were eligible for the study, and 527 agreed to participate. Those who refused to participate were similar on all variables, except they were younger in age than the studied sample. The authors found that the more resilient the personality resource such as self-esteem, perceived control, and optimism the women had to call upon, the less likely they were to appraise their upcoming abortion as stressful. The second part of appraisals takes into account how individuals cope given the options that are perceived as available to each individual. This study also found that the more positive the woman's cognitive appraisal, the more effective her coping strategies were after the abortion. Positive appraisals were defined as engaging in acceptance and positive reframing, and negative appraisals were seen as avoidance and denial.

Mueller and Major in 1989 studied 283 women undergoing a first trimester abortion at a private abortion clinic. The women were either assigned to an attributional intervention group, coping expectation, or control group. Each intervention lasted for 7 minutes. The attributional intervention was designed to minimize the women's self-blame for their pregnancy. The coping intervention was designed to increase their expectations for coping successfully with the abortion. The researchers found that the interventions did help women's postabortion adjustment when compared to the control group. The attributional group reduced the report of negative mood, and the coping-expectation intervention significantly reduced depression as well as anticipated negative consequences. Both groups showed a trend toward reducing physical complaints. The result which may be the most significant because it lasted not only for the responses immediately following the procedure, but also presented at the 3 week follow-up was

self-efficacy. The women who reported high self- efficacy or the belief that they expected to be able to perform a variety of post abortion coping behaviors, regardless of the intervention, were significantly less depressed, reported better moods, and anticipated fewer negative consequences. This research also found that women who blamed their pregnancy on their character or someone else, experienced more adjustment problems than those who did not.

Self-efficacy, or the belief that one can successfully execute behaviors that are required to produce the outcome that one desires, has also been found to affect the adjustment to abortion (Bandura, 1977). In 1993, Cozzarelli studied 291 women who arrived at a private abortion clinic in Buffalo, New York for a first-trimester abortion. The participants filled out a pre-procedure questionnaire packet, a post-procedure questionnaire after recovery at the clinic, and a 3 week follow-up questionnaire. Only 38% of the 291 women completed the 3 week follow-up. The pre-procedure packet contained measures of self-esteem, optimism, perceived control, self-efficacy, and initial depression. The post-procedure questionnaire measured depression and mood, and the follow-up packet was identical to the post-procedure one. The study found support for the hypothesis that when examined independently, self-esteem, optimism, and perceived control had effects mediated by self-efficacy at the immediate and 3 week follow-up. Self-efficacy continued to have a direct effect on the 3-week psychological adjustment, even when controlling for the effects of the immediate postabortion adjustment. This reflects the motivation nature of self-efficacy, in other words women who felt some mastery of the situation were able to imagine themselves handling the abortions well, and translated these expectations into incentives and guides for effective coping. The finding

that self-efficacy was a better predictor of adjustment than personality variables may be due to the fact that self-efficacy is more likely to generate goals that are specifically adapted to the requirements of a particular situation. It must be said that when examined separately, the personality factors of self-esteem, optimism, and perceived control had small direct effects on immediate psychological reactions, which may show an overlap between this set of personality variables and chronic preabortion adjustment.

Major, Mueller, and Hildebrandt (1985) interviewed 247 women who underwent vacuum aspiration abortions at a private abortion clinic in a large metropolitan area. Subjects were surveyed within an hour prior to the abortion about factors that they blamed for their pregnancy, and how well they expected to cope. After a 30 minute recovery period, they were surveyed about physical complaints, mood (Beck Depression Inventory), and degree to which they predicted future negative consequences. As predicted by the researchers, women who blamed their pregnancy on their character coped worse than low self-character blamers did, but self-behavior blame was not related to coping. Also women who had high expectations for coping before the abortion coped much better than those with low coping expectations. This form of coping, termed anticipatory coping by Lazarus and Folkman in 1984, is defined as the time an individual may anticipate problem-solving strategies, use cognitive coping strategies, or mentally rehearse behavioral responses to the situation. This anticipatory coping has been found to heighten sense of control and lead to better adjustment.

In addition to studying coping itself, Cohan and Roth (1984) studied 55 subjects in Raleigh, North Carolina at a gynecological surgical center to determine coping styles. The coping styles were categorized using approach and avoidance metaphors to describe

cognitive and emotional activities that cause an individual to either move toward or away from a threat at an unconscious level. For aborters, an avoidance coping style would include not talking about it, staying away from reminders of the experience, and avoiding feelings associated with it. On the other hand, an approach coping style would include behaviors like talking about it, thinking of ways to prevent it in the future, and trying to deal with subsequent emotions. The subjects were asked to fill out questionnaires upon arriving to the clinic, in the recovery room and about 5 hours later. Overall, most of the women showed a fairly high level of anticipatory stress marked by anxiety, depression, denial, and intrusion symptoms. It was also found that there is consistency in the use of a preferred coping style over time. The researchers differentiated 4 different types of coping styles: high approach-high avoidance; high approach-low avoidance; low approach high avoidance; and low approach-low avoidance. The “high avoiders” were found to experience more distress while “low avoiders” and “high approachers” decreased in stress over time, while the “low approachers” did not.

Research has identified several demographic factors that impact a women’s reaction to abortion. It was found that women under 19 years of age and women who do not have children have the most negative reactions post-abortion. The longer the length of the pregnancy before it was terminated also produced more negative reactions. Ethnicity may impact this by a longer period of time before pregnancy is discovered therefore producing the negative effects of abortions done at later gestations. When all literature is taken into account, most women who have made non-coerced and non-ambivalent decisions are satisfied with their choice, and would make the same choice

again. It was also shown that women with greater self-esteem and self-efficacy cope better post-abortion.

CHAPTER THREE

METHODS

The aim of the study was to examine the experiences of women who have had abortions. In order to accomplish this, I interviewed six women who were at least three years post-abortion, and had a clear recollection of the experience. The interviews focused on decision processes, predicting future responses and implications, resources, and coping.

Procedure

The questions used for the interview were designed using the stress and coping theoretical framework as a guide to elicit information about stress responses, appraisals, coping, and resources. I began by introducing myself, and sharing relevant background information. The participants were asked to read and sign the informed consent (Appendix A) if they wanted to participate in the research. They were then asked to fill out the demographic questionnaire (Appendix B), which consisted of 10 short answer questions. The interview included 18 different questions. The first question was used to get the participant talking, and was basically, “what do you think would be important for someone who was studying abortion experiences to know?” It was then followed by 17 more specific questions (Appendix C), and even if I felt the participant had already answered the question, clarification or more detail was elicited by the specific questions. The questions covered a vast amount of the participant’s life which included information before the pregnancy up until the present.

The Interview

To obtain a retrospective viewpoint, direct interviews were performed. The interviews took place in a private classroom at a graduate center. One face-to-face interview was not possible, and was conducted over the phone. This was necessary because the participant lived several hundred miles away. All interviews were audio taped, and on the average lasted approximately 70 minutes.

Appendix C is the list of questions which were used to guide the interview. The questions were open-ended and were used to elicit information about the decision process, coping, and resources. The list was used as a guide for the interview, but as responses were collected, I used follow-up questions for more clarification or depth. I would also use statements to clarify ideas or concepts that the participants were expressing.

After each interview, the questions were reviewed and compared to the theoretical framework in order to better address the concepts that were being studied. The questions were changed very little, but 3 more questions were added to gain more depth to concepts.

Participant Selection

In order to obtain a balanced perspective, I tried to avoid recruiting participants who would be at the extreme ends of the experience. For example I avoided posting notices about the study at religious or pro-choice businesses. After receiving approval from the Institutional Review Board at Virginia Tech, I began posting flyers at numerous locations in the Northern Virginia area. Such locations included the Northern Virginia Graduate Center, supermarkets, libraries, and other locations with bulletin boards. I also

contacted colleagues, family, and friends to see if they knew anyone who might be willing to participate. I tried to share information about my research with as many people that I came into contact with as possible, in the hopes that someone might know someone who would be willing to participate in the research. If anyone thought they might know of someone, I would give them flyers to give to individuals or post at their work, health club, etc. As two months passed, and I had only received three calls, I intensified my recruitment by reconnecting with people I had spoken with earlier, and posting flyers at new locations. The flyers (Appendix E) had my name and private voice mail number on them. Participants called and left a message that they were willing to be interviewed. Upon calling them back, I made sure that they were over 18 years old and were at least 3 years post-abortion. If these criteria were met, I scheduled interviews at a time and location that was convenient to the participants.

Confidentiality

The identity of the women chosen for the study has been kept confidential throughout the entire research process. Their names were never written on the audio tape of the interview, nor the transcription. A number was used in place of the participant's name to match their interview with their demographic information. This code remained through the process of the data analysis, and will remain until its final printing. At no time will the participant's name be associated with the information they had given the interviewer. The participants were given pseudonyms, and any specific information, such as names of others or place names have been changed to protect their identity.

Participants

The participants in the study were all over 26 years of age, and gave retrospective accounts of their abortion experiences. There were 6 participants who ranged in age from 26 to 52. The average age of the sample was 39. All of the participants were Caucasian except one who was Hispanic. Geographically, all lived in the Washington, D.C. metro area, except one participant who resided in Texas. The women ranged in age from 18 to 39 when the abortion occurred, with an average age of 24.8. The length of pregnancy when they discovered that they were pregnant ranged from 2 weeks to 9 weeks, with an average of 4.7 weeks. The women ranged from 2 to 16 weeks gestation when their abortions occurred, the average length of gestation was 8.7 weeks at the time of the procedure. Only one of the participants was married with children at the time of her abortion. Four of the participants were Catholic at the time of the abortion, and one has since left the church. One of the women had no religious preference at the time of the abortion, but is currently Greek Orthodox. The other participant is Presbyterian. Five of the six participants are currently married, and 3 of them have children. Only one participant had children at the time of the abortion. At the time of the interview, one participant reported that she and her husband were in the process of trying to conceive a child. Three of the participants had college degrees at the time the abortion occurred. One was in the middle of her bachelor's degree, one was a high school graduate, and one had her Master's. Since the abortion two of the college graduates have begun graduate programs, and the participant who was finishing her bachelor's has received her Master's. The participant with the high school diploma has taken college courses, but never received a degree. The demographic data for the participants is provided in Table 1.

Data Analysis

The interviews were transcribed by a transcriber. The interviews were then sent to the participants to make any corrections or clarifications to their interviews. Beginning with the first interview, each line of the participant's responses were open coded. The first interview was then cross-coded by the chair of my research committee. The first two interviews were coded to determine general themes and areas of importance. The data analysis was conducted in a manner consistent with data collection as described by Strauss and Corbin (1990).

	Missy	Geri	Joan	Kristen	Margie	Allison
Current Age	41	30	52	44	41	26
Age at Abortion	26	24	39	20	18	21
Gestation When Pregnancy Discovered	2 Weeks	3 Weeks	4 Weeks	9 Weeks	6 Weeks	4 Weeks
Gestation at abortion	2 Weeks	6.5-7 Weeks	6 Weeks	13 Weeks	16 Weeks	8 Weeks
Married at Time of Abortion	No	No	Yes	No	No	No
Children at Time of Abortion	0	0	3	0	0	0
Currently Married	Yes	Yes	Yes	Yes	Yes	No
Number of Children	0	0	3	2	2	0
Ethnicity	Caucasian	Caucasian	Caucasian	Caucasian	Hispanic	Caucasian
Religion at Abortion	Catholic	Catholic	Presbyterian	None	Catholic	Catholic
Current Religion	Catholic	Catholic	Presbyterian	Greek Orthodox	Catholic	Searching
Education at Abortion	College	College	Masters	2.5 College	High School	College
Highest Degree	Masters	Masters	Masters	Masters	High School	College

Table 1

The third interview was coded to determine more details about the themes that had emerged in the first two interviews. After coding the first three interviews, the interview questions were modified slightly to probe deeper to access more information on certain topics. The researcher wanted to discover how similar themes fit into concepts discussed in the stress and coping theoretical framework. For instance, if the participant said that their views had changed, questions were asked about their viewpoints before the abortion to understand more about their reappraisal process.

As the last half of the interviews were analyzed, additional themes emerged. As these were discovered, earlier interviews were examined to see if the themes were new or were previously overlooked. As the lists of codes grew with each interview the process became sorting through the codes to see how they related to each other. As themes emerged, they were separated first according to timeframes: before, during, and after the abortion. Within these three main categories themes were arranged under each topic and subtopic. Using the Ethnograph software a “family tree” was created that arranged the codes in an outline form, which connected ideas (See Appendix D for abbreviated version of this).

This family tree was then used to see connections and commonalities between the interviews. This was used to create themes that fit into the theoretical issues that were presented. The software also enabled the data to be sorted according to each participant to see where their themes were different.

CHAPTER FOUR

RESULTS

The following section is designed to give a rich description of each of the participant's unique experiences. Each participant's story is divided into three parts: before the abortion, during the abortion, and after the abortion. The women's own words are used (in italics) to give a more accurate description of the narrative. In bold are themes that were common for many of the participants. The term listed first is the terminology used by the stress and coping model from my theoretical framework that applies to the topic being discussed. The terms listed second are used to develop common themes among the women. The final section of this chapter will discuss these terms and how they were relevant to the theoretical model.

Missy

Before the Abortion

Missy is a 41 year old Caucasian woman who grew up a Catholic family where her father was in the military [**personal constraint- Catholic beliefs**]. She had her abortion 15 years ago at what she thought was about 2 weeks gestation, right after she discovered the pregnancy. Missy's pregnancy was the result of a date rape. She is in recovery from bipolar disorder, alcoholism, and an eating disorder. She describes her abortion as part of what she considers hitting her "rock bottom", and sees it as one of the reasons she went into recovery. She said she never considered any other option than abortion, because not only was she unmarried and felt that single parenting was not an option for her, but she felt it would definitely hurt her Navy career [**primary appraisal- threat to career**]. She had a long career in the Navy and explained that her whole

identity at this time was her job. She explains that since her entire identity was her career, and she was very judgmental of other women who had gotten pregnant out of wedlock. She also talked about the fact that she was an alcoholic during this time period. As she described it, “Not the falling down drunk kind of drunk,” but described a life full of addictive behaviors [**problem-focused coping- self medicating**].

She talked about making the decision to abort almost immediately, and did not seek out information or other’s opinions [**primary appraisal- made decision quickly**]. She said she did not believe the abortion would have any impression on her at all, and thought it would be quite manageable.

P:But I wouldn't trust anybody when I made the decision to have the abortion. And I say in meetings sometimes, I was drunk before, I was drunk during, I was drunk after. I was drunk during the abortion process. And I wouldn't have listened to anybody, except probably somebody who had been through the experience themselves and could have shared from their own experience what it was like. That person I probably would have listened to.

R: Do you wish that had been provided to you at that time?

P: Yes. And maybe some of the people who talked to me, I don't know what they told me at the abortion clinic, I mean I knew -- I was totally self will run riot. I knew that I would – I knew that I was going to have the abortion no matter what anybody said to me, so I tried not to listen to them trying to talk me out of it. And they may have said – and not necessarily – they didn't exactly try to talk me out of it. They tried to get me to be objective about the process that I was going through

and, you know, it just – it just didn't hit me. It didn't hit me at all [primary appraisal- limited information].

During the abortion

Missy got the man she was dating at the time to drive her to the clinic. She explains that she did not “let him in,” meaning that she did not let down her guard and share any emotions with him. She stated that she thought that he might have had compassion for her, but she was shutting him out too. She did not go into any detail about the clinic or the procedure itself. This lack of recollection could possibly be viewed as a dissociation to help her manage the stress she was experiencing.

After the Abortion

Initially after the abortion, Missy describes coping as self-destructive. She said she was drinking, smoking, and having sex. She said she used these to avoid painful issues and keep herself out of the present. She even remembers that the clinic told her not to have intercourse after the procedure for a specified amount of time, and she could not abide by their suggestion. She remembers busying herself with her career, and not experiencing any feelings associated with the abortion for the two months following the procedure [**emotion-focused coping- avoidance**]. She believed, at the time, that the procedure would have no impact on her life.

R: How confident did you feel that you could control how much the abortion would impact your life?

R: Oh, I thought that I could go in on whatever day of the week it was, I think it was a Saturday because I didn't want to miss work. I think I could go in on Saturday and wake up on Sunday and it would all be over. I was upset that they

told me, after I had the abortion, I couldn't have sex for so many days. I thought how am I going to cope with this with not having sex. And of course I disregarded those instructions, I went and had sex anyway, because that was one of my coping mechanisms. And – no, I thought I could – I thought it would be quite manageable.

P: So did you predict that your response would just be nothing?

R: Yeah. I didn't think it would have any impression on me at all.

The turning point for Missy was getting sober. She describes her sobriety as starting two months after the abortion. It was then that she let a “Higher Power” into her life and saw that “her pride was getting in the way of her asking for help.” She stated that she felt AA and religion has been essential to her sobriety and coping [**resource- AA and religion**]. She describes adopting a healthy lifestyle, and nurturing herself on a constant basis [**problem-focused coping- adopted healthy lifestyle**]. She also stated that the single most important coping mechanism for her has been working with other women who are thinking about or have had abortions [**problem-focused coping- shared experience**].

R:So your decision basically changed over time after the abortion that really would affect how you viewed things. I guess you're in a different place now in your life?

P: Absolutely.

R: Your priorities?

P: Absolutely. Yeah, I got sober. That changed everything.

R: Really. How do you see that? How do you see getting sober changed everything for you? What kinds of things changed in your thought patterns or the way you make decisions?

*P: I stopped being self-destructive. And I want to say in all areas of my life, but that would imply that I'm perfect, and I'm not perfect. I still drive fast, for instance, and that's a little bit of a self-destructive tendency. But generally I work on loving and nurturing myself on a daily basis. With proper eating, you know, proper nutrition, with keeping substance free, with being present for not only my employer but also my friends and my family, and just living in a world that's filled with love and nurturing as opposed to just the hell that I lived in at the time that I had the abortion. I mean my life was so reckless – so reckless at the time. I was promiscuous. You know I would work these 20 hour days. I would eat nothing but sugar and fat, like 24 hours a day for days on end. When I wasn't spending time at work, I'd be sitting in the bar drinking beer. You know, I had this very shallow, destructive life back then **[reappraisal- realized and stopped destructiveness]**.*

She now says that if she had been sober, she could never have had the abortion.

She now views her decision as killing a child, and would not make the same decision if faced with the same situation currently **[reappraisal- saw abortion as killing child]**.

Missy understands that her life is much healthier now, and she sees her ministry to help others in her situation or who are considering abortion. She was also able to share her experience with her family, who she says has been very supportive of her **[resource-family]**. She feels they have forgiven her for the decision she made, but most

importantly she has been able to forgive herself. As she reported, she did not think that the abortion would have any affect on her life, but once she went into recovery, she stopped masking her feelings with substances. She identified the most prevalent feeling as guilt, but believes she is a survivor, and is coping well.

R: Anything else that you feel is important for me to know, or anything you did not get to mention.

P: I think you just mentioned it, that I think that is what I would see myself as, as an abortion survivor. You know, not -- as an abortion survivor in the same way that an incest survivor calls him or herself an incest survivor, I would say that I am an abortion survivor. I don't – I think it's very easy to do – it's probably very easy for women who are in the midst of this decision to scoop it under the carpet like I did and say, "It's no big deal." Well, it is a big deal, you know, it really is a big deal, but there's always a way to get through it, you know [reappraisal-abortion did affect her life].

Geri

Before the Abortion

Geri is a 30 year old married Caucasian woman who had her abortion 6 years ago. She discovered she was pregnant at 3 weeks gestation, and had the abortion about the 7th week. When Geri found out she was pregnant, she was newly engaged, and had just begun a career. She came from a background in which her parents and her best friend were Catholic [personal constraint- Catholic beliefs]. When she found out she was pregnant, she could not imagine having a child because of its impact on her career, and future plans. She reported that her fiancé did not want her to have the child, and she

based most of her decision on his opinion. She was also afraid that if she took time off from her business career she was just starting to have the baby and went back to work, she would not be viewed as an equal [**primary appraisal- threat to career**]. She made the decision quickly, because she had been with a friend who had an abortion at 12 weeks, and had severe medical complications following the procedure.

R: Any kind of strategies that you applied in the decision making, and did they change over time from the time you found out you were pregnant? Any kind of thinking that you used?

P: You mean between the time I found out I was pregnant and then actually had the abortion?

R: Yes.

P: No, simply because I did it so quickly. I knew almost immediately that I was pregnant. I mean I think I knew like within two weeks, and I tested positive at three weeks, and I had it at the very first possible date that you can do it legally, which is six and a half weeks. I just – and the reason I did it so quickly and I didn't give myself a lot of time to think is just because I had actually gone with a close friend about two years before, and she waited – she backed out at like nine weeks, and I took her again at ten weeks and she backed out again, and she waited until the last possible limit of 12 weeks and had complications really badly. And it was so painful. And I watched her struggle through that, and she became a different person just because it was hard enough a decision she made, but then everything on top of that, all the complications and having to go back, and they weren't very nice to her.

And so when I found that I was pregnant, and when I kind of realized that that was my only option, I just wanted it done as soon as possible. When it would be quickest and less dangerous.

R: So this strategy was basically to get it done as quickly as possible?

P: Yeah [primary appraisal- made decision quickly].

She limited whom she spoke with to her ob-gyn physician and his nurse. It was not until after the abortion that she looked at a developmental book on fetuses, and stated that if she had seen it before her decision, she probably could not have gone through with it. She also admitted that she did not seek advice from a priest because she feared he would sway her decision [**primary appraisal- limited information**].

R: Did you think that you would have any feelings, any specific feelings?

P: No. One of the things I did is, I really – I mean I actually talked to my ob-gyn and a nurse before. And I let them know I was doing this just because I had the same doctor forever, and so I talked to him ahead of time about any potential physical problems that might come out of it, and I talked to the nurse about any emotional problems. So I really tried hard to think that I would be strong afterwards.

R: So you didn't think you would have any feelings about it?

P: I thought I might, but I thought that maybe by addressing it clinically and talking to my doctor and everything that I might get all the information and I might be better equipped to deal with it. But I don't know. I think – I don't know. I remember reading a book right after – not right after, I think about a few months after it happened – a developmental book of fetuses. And when I saw

what a fetus was at like seven weeks, it really surprised me. And I thought if I had just gone a little bit further, then I probably wouldn't have made that decision.

During the Abortion

Geri said that making the appointment and showing up to the clinic were frightening. She also explained that there was added stress because she found out on the way to the clinic that her fiancé had spent the money she had saved for the procedure. Geri stated that up until the time the pregnancy was confirmed by a test before the procedure, she had a small hope that she would not have to go through with the abortion. She stated that the worst part for her was the feeling of total loss of control, when they sedated her to begin the procedure.

P: Oh, it's really scary. Scary making the appointment, scary showing up. You know, everything up until the actual procedure is just very frightening. When you get there and they take another test just to make sure, and of course you get this one flicker of hope that maybe I really wasn't and maybe this won't have to happen today. And then of course they completely shoot that down when they confirm that you are. And the very worst part of it – like I said, I think I tried to focus. I was very scared and I was also very angry.

R: At him?

P: You bet, angry at him. But I knew it was something I had to do and I found out and I called my doctor and I asked him to refer me to a place, because I didn't want to go back to that other place that my friend had gone to, and made the appointment as quickly as possible, and counted the money. And like I said, it was just boom, boom, boom, boom, I was just going to do it. And the hardest part

was actually when they were putting me out for the procedure because then, once they do the IV and the doctor's there and the nurse is on the other side of you, once they put the medicine in, it's too late. There's no turning back. And that's the part of it that I will never forget and I wouldn't have wanted somebody to witness because when I went under I was crying. And at that point, 'cause the medicine is taking you under, even if you continue and say no, the words aren't going to come out. And that was the worst part of it. That was the most emotional part and that was the part that sticks with me to this day.

R: Sounds like it was a feeling of almost a loss of control?

P: Complete. Absolutely.

After the Abortion

After the abortion, Geri believed she could throw herself into work, and everything would be fine. She explained that she felt “emotionally numb” [**emotion-focused coping- avoidance**]. She found that her fiancé was not supportive, and she felt like she had no support and no one to turn to. She felt that her choice did not affect her work but stated that, “personally it affected everything.” She was caught off guard by these feelings because she did not believe it would affect her life [**reappraisal- abortion did affect her life**]. She would come home from work each night, and go to her room and cry. It was about two weeks after the abortion that she confided in her parents, who despite their Catholic beliefs that abortion is wrong, were very supportive [**resource-parents**]. She felt that if she gathered enough information from her doctor, she would be strong enough not to experience any negative emotions afterward. In her former marriage, they had made the decision to not have any children, based on the fact that it

would be too difficult given the failing relationship, and the stress from the abortion. Geri reports that her current husband is very supportive, and knows about the abortion **resource- current husband**]. They have considered having children, and she said she thinks it may be “a little bit difficult” given her past experience, but believes “it will be a good thing when it happens.”

P: They didn't support the decision, but they supported me and they understood how painful it was. And in the years since we've been able to talk about it openly. You know, it's a painful thing to discuss but my parents were really instrumental in helping me through that.

R: What did they do that was so helpful to you?

P: They – I guess I had to be strong throughout the entire process because my fiancé, which is a whole other story, he just shut himself off, basically. I made the decision – I guess if he had said, “Have it,” I would have had the baby. And when he said, “Don't,” I said okay. And that kind of told a lot of where our relationship was heading, that he couldn't handle that, and there were a lot of things he couldn't handle. So I had to be strong, but I kind of fell apart afterwards, and my parents really helped me get through it because they let me cry on their shoulders and they let me – you know, even though it had already happened and I had made it through it, they kind of just let me let my guard down finally, and, you know, all the stuff I couldn't stew up until then because I had to – I didn't have a choice, I had to go through it.

She also felt like her doctor was a resource to her because he reframed the experience in a positive light stating, “at least now I know that you can have children”

P:So afterwards, I went to see him shortly after the procedure to ensure everything was okay, and I really just cried -- and he was really, really great, and he said, "I look at this as a blessing," he said, "because I know now that you can have children." And he was a huge help. I will never forget that.

R: So the fact that he thought of something positive?

P: Yeah.

P: And it sounds like he wasn't blaming you.

P: Not at all. Not at all. He was strictly professional and he helped me – he helped me to get something positive out of the whole thing, because I wasn't really getting anything positive out of it. So I hadn't even thought about that, but he did help me through that.

R: So your parents were pretty instrumental, and the doctor. Anything else you can think of [resource- parents and ob-gyn physician]?

P: My two best friends, they were supportive of me. We didn't really talk about it but they were just there for me. They were there for me and they considered me to be their best friend [resource- friends].

She reported that she is not sure if she has ever actually coped with all of the emotions that resulted from the abortion, but she talks openly with her husband or parents if she experiences negative emotions. She reported that she feels she constrained her abilities to cope by avoiding it and not following her gut instincts. Geri's experience is something that she feels she lives with daily, for example seeing a child, a pro-life bumper sticker, or acquaintances having children. She also stated that after her divorce, she was

diagnosed with clinical depression, and went to therapy. She stated that she told the therapist about the abortion, but they never discussed it.

Joan

Before the Abortion

Joan is a 52 year old teacher with a Master's degree. She has been married for 33 years and has 3 daughters. She had the abortion 13 years ago, after a birth control method failed, and she was faced with a 30% to 40% chance of having a child with severe complications. She had been told after the complications with her 3rd pregnancy not to get pregnant again, and she states that the 4th pregnancy was a complete surprise. She said she made the decision to abort herself based on the fact that she did not feel like she or the family could handle the stress of having a child with complications. She knew if she waited long enough in the pregnancy for the results from an amniocentesis, she would not be able to abort that far along if handicaps were found, and she knew she would not be able to give it up for adoption. When faced with an unplanned pregnancy, Joan thought mostly about how a handicapped child would affect her other 3 children as well as her marriage [**primary appraisal- threat to family and marriage**]. She feels like she used the fact that there was a chance of medical complications to justify her decision to abort. She remembered that her doctor was very objective and clear cut about what the risks were. He gave her literature to read, but she did not think she read it saying, "I think it was like I don't want to know-the less I know, the less I have to think about it."

P: I felt trapped. I felt very frightened. I felt – I mean I was 39, I had had my first child at 26, my second at 30, had always planned to have a third child and,

you know, it got delayed with, oh, we'll, we're moving, we're changing jobs, you know, next year, next year, next year. And then it was like, well, wait a minute, I don't want to be 40. So I had my third child at 37. Getting pregnant at 39 was daunting. Financially it was not a problem. I think it was more emotionally, and I honestly didn't feel like I could deal with the prospect of the severely – well, either the death of the child at some point or a severely handicapped. Even though we were only really talking -- if I can remember this – I want to say we were only talking like maybe a 30 to 40 percent chance that that would happen. So there was still a fairly – but I took that, I took that excuse. I can rationalize that I had a legitimate fear, but my heart still tells me that I was a little bit of a coward here, I took the easy way out [reappraisal- felt like a coward].

She knew once she felt the baby move, she would not be able to follow through with the procedure, so she wanted it done as soon as possible. She felt her husband was supportive of her, although she never asked him what he wanted her to do with the pregnancy. Joan saw the decision as a temporary stress versus the lifelong stress of a disabled child [primary appraisal- limited information and made decision quickly].

During the Abortion

Joan found the procedure to be more stressful than she had predicted. Joan remembered the suction sound of the procedure as the most stressful making her feel nauseated. She also stated that she wished she were able to have an anesthetic.

P:But, you know, it was handled very professionally, and I mean there was no one in the waiting room that would suspect I was in for anything other than either a gynecological visit or most likely for a pregnancy, since my husband was

with me. I did get anxious, when I did get into the room, I asked about – at that point I felt very anxious and asked if I could have a sedative, and at that point it was too late. You have to have it – and I do remember feeling resentful that I was more conscious than I wanted to be. And I do remember, not as vividly as I did in the first couple of years, but I did think that it would be soundless, and it's not. And that was, I think, the worst part. It was not, you know – you've had three kids, you've had, you know, how many hundreds of pelvic exams and everything, that part of it didn't feel out of the ordinary, but the sound was – made me feel nauseous, because it was like such a realism, I mean this was it. You know, in your mind you can say, you know, this really isn't happening, but hearing this vacuum –[environmental constraint- not enough information]

After the Abortion

After the procedure, Joan described wanting to, “crawl into my bed, bury my head, and pretend this day never happened” [emotion-focused coping- avoidance]. She talked about wishing she could call her friends to support her during this time, but she was afraid that they might judge her decision. The only person that knew at the time of the procedure was her husband. She has since told her two daughters when they were about 18 years old, for the purpose of teaching them about failed birth control. She said she also shared her experience with her daughters because she still feels some guilt, and never wanted them to get into a situation in which they had to choose whether to abort a pregnancy [problem-focused coping- shared experience]. She said that even to this day she still thinks about the abortion, and wonders what may have been different had she not terminated the pregnancy.

R: What did you predict? I mean did you think it would be – you'd go home and everything would be fine and you'd never think about it again? Or I mean what did you think your response would be?

P: Well, you know, I thought – I really did think that, oh, it'd probably be on my mind for a couple of months. It's been 13 years. There are still times – and I can't tell you what triggers it, I really don't know – there'll be times when I'll be, oh, you know, reading a book or drinking coffee or walking the dog or something, and I'll think to myself, "What if?" Or, "I wonder if it was a boy." Or, "Maybe I should have been braver and taken a chance" [reappraisal- felt like a coward].

Joan also shared that Lamaze breathing and avoidance, such as burying herself in a book, and prayer have been tools she has used to help her to cope through stressful times [emotion-focused coping- avoidance][problem-focused coping- prayer and Lamaze breathing]. She also stated that she was glad she was Presbyterian because in her faith she would still be allowed to take communion. She felt the most stress in making the decision, and identified her husband and doctor as resources [resources- husband and ob-gyn physician].

Kristen

Before the Abortion

Kristen is a 44 year old Caucasian wife and mother of 2. She was 20 years old and a college student at the time of her abortion. She was about 9 weeks along when she discovered the pregnancy. The abortion was performed around the 13th week of gestation. Kristen spoke about growing up in a family where her mother spoke to her and her sister about pro-choice views. She said that her mom always told her that women had

the right to choose to end a pregnancy. She felt that she had adopted these views, and that they made her decision easier. When she found out she was pregnant she stated that she was not in a stable relationship with her boyfriend at the time, and did not want to have a child alone. She also described having some anger toward herself and the father because they had gotten pregnant. She briefly thought that giving a child up for adoption would “haunt” her. She said she might have considered having the baby if the relationship was better or if the father had insisted that she keep it, but she stated that he was happy not to have to deal with it. In making her decision, she focused on how a child would impact her education as well as her relationship with her parents. She wanted to continue college uninterrupted and also felt that her parents would be angry and disappointed [**primary appraisal- threat to education and relationship with parents**]. More than anything she was clear that she did not want the consequences that would come along with a pregnancy.

R: Is there anything that you feel like you kept yourself from exploring options, or do you feel like you were pretty open to any options?

*P: That’s a good question. H’m. I think I quickly looked at the other options, which would be, you know, have the child and keep it, have the child – or put the child up for adoption, and just kind of said no, that’s not going to work. I didn’t really spend a lot of time on this decision. You know, I was certainly aware of them but I just sort of like, yeah, that’s not going to work for me, and pretty quickly moved to that the abortion was what I needed to do [**primary appraisal- made decision quickly**].*

R: Okay. And it made you comfortable with that decision because you thought about the repercussions that it would have on your family and your education?

P: Yes.

During the Abortion

Kristen explained that the father of the baby went with her to the abortion clinic for the procedure and she was very nervous going in. She described that she felt that he was there physically, but that he was not supportive of her emotionally. She remembered that they explained to her in a group about the procedure, and answered any questions that arose. She said that they procedure was painful and she was nervous because they had neglected to give her a sedative. She recalled feeling that the woman who stayed with her during the procedure was very warm and caring, which eased some of her tension [resource- clinic staff]. She said that she recalls that the procedure was over rather quickly, and after she felt an overwhelming sense of relief. After the procedure the woman who was with her brought her some juice and cookies, and she was relieved that the nausea she had been experiencing was already gone.

P: I was very nervous. The woman that explained – she had a group of like five or six of us that she kind of explained the physical steps of the procedure. I remember her as being a very warm and caring person and that was helpful to me.

R: What kinds of things did she do that was helpful?

P: I think it was just her whole manner. I mean she was discussing the physical steps, but she wasn't sort of cold and clinical about it. And she was concerned that you had someone there to support you and that, you know, you would have someone that would be supportive afterwards.

After the Abortion

Kristen explained that she was glad she had the option to terminate the pregnancy. She said that she predicted that she would be relieved, and in the past 24 years she has not had any regrets or negative feelings about having had the abortion. She said that she examined her feelings about the abortion very carefully during her pregnancies with both of her children, and they have not changed.

R: Did those feelings of relief ever change down the road, or did that hold steady for you?

P: That's really held steady for all these years. Even true—you know, because I've examined those feelings. Especially when I was pregnant with my children, or when they were infants. I just think it all came down to, does this change, you know, now that I'm pregnant with a child I want, now that I have a baby that I wanted, do I feel different about that. And I really don't. You know, I really feel like I made the right decision, and I really don't have any negative feelings or any regrets.

In retrospect, the only thing she would have liked to do differently was to have someone go with her and after the procedure who was emotionally supportive. She said that her best friend from high school supported her decision and helped her to get the money for the abortion, but would not accompany her to the procedure [**resource-friend**]. One of the coping mechanisms she described was a constant focus on her future, and busying herself with schoolwork and exams [**emotion-focused coping- avoidance**]. She described that she felt in control of planning the details such as getting the money, finding the clinic, and transportation and did not experience self-doubt. The only thing

she would change would be to have had someone more supportive go with her to the clinic to be reassuring. She did remember a counselor that was caring and held her hand during the procedure and checked on her afterward eased her stress. She told me that having her abortion did not spoil her ability to enjoy her pregnancies or children when it was the right time for her. She would also caution women choosing abortion to be careful who they share it with, because she said having someone criticize her decision would cause some stress.

Margie

Before the Abortion

Margie is a 41 year old Hispanic woman who had her abortion when she was 18 years old. She is currently married with 2 children, and works as an office manager. She discovered the pregnancy at 6 weeks, but did not have the abortion until the 4th month. She was dating her current husband at the time, but does not think that the baby was his, and does not believe that she ever shared this information with him. Her boyfriend (current husband) told her that he would marry her and they would have the baby, or he would support her in whatever decision she made [**resource- boyfriend**]. She grew up in a home with a very religious Catholic mother and her father was Methodist. She said she had always considered herself pro-life based on the teachings she had received in Catholic school [**personal constraints- Catholic beliefs**]. When she found out she was pregnant, she consulted a priest and her friends. The priest told her the church's teachings, but gave her his honest and sincere thoughts about being able to be comfortable answering to God for whatever decision she made. Her friend suggested that she read a book on women's bodies, which explained the abortion procedure. She also

consulted her mom, who although did not believe in abortion, told her she would support her in whatever decision she made [**resources- mom, priest, and friends**].

She said she felt that having a child at that time would hold back her dreams and it would start out the child's life in a bad situation in which she was not able to provide for it. She said that she and her mother had dreams of her going to college [**primary appraisal- threat to education**]. She spent a lot of time gathering information to make her decision because she said she did not want to doubt whatever decision she made.

P:So I felt like it was the best decision that I could make at that time for the circumstance. And that's just how I dealt with it. I went in and I decided that this is what I wanted to do. And when I went to my Mom, she kept saying, "Are you sure? Are you sure this is what you want to do? Are you sure?" And I was like, "Yeah, I am." And you know, she's like, "You have to be like so sure that this is what you really want to do because, you know, once we start this," -- and she knew that we had to do it behind my Dad's back -- so she's like, "Once we start this whole thing, you can't turn around and back out." And I understand because I think that she felt like she was betraying my father in keeping it a secret. So if I decided like after we went to the doctor and the hospital and the whole thing and I was admitted, and then decided on the table that I wasn't going to do this thing, that not only would there be a doctor's bill, a hospital bill and all this other stuff, but there would also be -- she'd have to go, "Oh, and by the way, she's two months pregnant," or whatever.

So I think that she felt like, you know, "You have to be sure if we're going to do this," to do it. And so when I -- I just felt that I was very, very sure that I was not

going to have I want to say a feeling like I had made a bad decision after I had done it.

Like I wasn't rushed into it. I talked to a lot of people about it.

Margie explained that once she had made her decision, her mother made all the plans for her abortion through their health insurance. Through the entire process they kept it a secret from her father.

During the Abortion

When she arrived at the hospital she remembered that a nurse and a counselor sat down with her to make sure she knew her options, and that she was sure about her decision. She said her mother was holding her hand and she was very scared when they began the procedure [**resource- mother**]. She experienced a lot of pain and was not prepared for the things that were happening. She remembers the most traumatic thing for her was sitting up and seeing the fetus after it was delivered. She said it was at that moment that the realization of what had just happened hit her.

R: So you think your fear increased during the procedure?

P: Oh, yeah, a lot more. I was a lot – you don't know if they're doing stuff right, like when she was doing the needle, I kept thinking, "She is slicing my stomach open," because it hurt so bad as it was going through your muscles into your womb. It hurt so bad, I thought that she had actually taken like a hot knife and was – I mean I had like – I mean I stood up and looked because I was starting to freak out that she was ripping me open. I didn't understand why it hurt so bad.

P: And when you start dilating, they put like I guess it's a wood chip or something, I don't know, I don't remember what she told me, something inside you, and also give you I thought it was hormones, it might not be, but it's some drug that actually makes you go into labor. And then with that it starts dilating you and everything. And that was very painful. It was like having cramps like when you're on your period. So it was like – I was like, “Do you guys know what you're doing?” I mean, “Is anybody aware of what” – and I guess not knowing what having a baby – I guess if I had seen a film about having a baby and, you know, mother screaming and the pain and the whole breathing and the whole everything, that I would have actually understood more of what I was going to go through.

R: So it was frightening?

*P: Yeah. I mean they did explain it to me, but she was like, “They're going to take you into this room, we're going to, you know, prep you, we're going to do saline, we're going to do this, we're going to do that, we're going to wait for you to dilate, we're going to bring you in here and deliver the baby.” I mean she was just like very short overview of what was going to happen when she explained everything to me. So when it started, everything started happening, I was like, “Oh, my God, do you know what you're doing? Is it supposed to hurt this much? Is it supposed to, you know, am I supposed to be this doubled over with cramps? Am I supposed to be feeling nauseous?” You know **[environmental constraint-not enough information]**.*

She believes the reason it was so painful, and the baby was so well formed was because she was farther along in her pregnancy than they knew. She believed this was one of the negative aspects to taking longer to make a decision.

After the Abortion

After the abortion Margie explained that she was very emotional and depressed. She said that this surprised her because she did not think she was going to be as upset as she was initially, and was not prepared for a depression period. She said that talking about it, praying, and crying all helped her to deal with her sadness [**problem-focused coping- talking, praying, and crying**]. Margie said that her mom was very angry with her boyfriend, but did not express anger toward her. Although she felt relieved after the procedure, she also went through a short depression and was very emotional, which surprised her. She used her friends and boyfriend to sort through the feelings she was having [**resources- friends and boyfriend**]. She says that it has been helpful over the years to share her experience with others [**problem-focused coping- sharing experience**]. She also believes that it is important for someone making the decision to be honest with themselves about how they handle stress, and if they will be able to handle any regret. She feels it is essential to have a support system that is not judgmental. She sought support from her friends as well as her mother. She also feels like taking control of her decision as well as the consequences helped her cope, versus friends that she saw that felt they were a victim of circumstances. She said the most important things for her, which she would encourage others to do, is give yourself a break and get support. She said that it also helped her to heal to share her experience with others. She said it was a very painful decision, and since then, she has supported several friends through the

abortion process. Each time she urged them if they decided to abort to do it as early as possible to avoid a late term abortion.

R: You said something about you were young and this was your one and only chance. Sounds like in retrospect you kind of let yourself – gave yourself a break?

P: Yes, for making a bad decision-for getting pregnant. You know, it was like, okay, I was very – when I was younger, I was very – I had such high expectations of myself, and I think you're your worst enemy a lot of times because you condemn yourself more than anybody else for different things. And I think that at that point I realized that I had to step back and give myself a break because of the fact that I could beat a dead horse to death, over and over and over again about it. And rather than do that for the rest of my life, that I had to walk away from it and almost pretend like it never happened. And then I realized that, through telling other people, of being there with other people, and telling them how I felt and what happened to me, that it actually made me feel better. You know, that the report actually made me feel better. So it was kind of a reciprocating kind of deal.

She stated that she sees herself as a survivor, and believes that this is much healthier than viewing herself as a victim of circumstance.

Allison

Before the Abortion

Allison is a 26-year-old Caucasian woman who had her abortion when she was 21 years old. She discovered the pregnancy at 4 weeks gestation and had the abortion 4

weeks later. Allison described growing up in a Catholic family that is very anti-abortion **[personal constraint- Catholic beliefs]**. At the time the pregnancy occurred she was not in a relationship, and had recently graduated from college and was beginning her career **[primary appraisal- threat to career]**. When Allison discovered that she was pregnant, she did not believe that she was at a place in her life where she wanted to have a child, especially since “the baby was not conceived in a loving relationship.” She said she did not consider adoption because she did not want anyone to know about the pregnancy, especially her parents. She said she felt she needed to get out of the situation as soon as possible, and tried not to think about it too much.

R: So you think your response to thinking about adoption would have been kind of embarrassment of having to deal with the pregnancy and –

P: Well, yeah, I don't know if it's embarrassment, but just sort of not wanting to have to face, you know, people's judgment or having to explain, you know. And I guess – I don't know if embarrassment is the right word. More of just not wanting to have to explain the situation.

R: What do you think – did you apply any strategies in making the decision? Like what kinds of things were you thinking about?

P: I went to the phone book. No, I mean I didn't really – I was sort of, as soon as I took the pregnancy test, I just – I knew that carrying it was not an option, I mean.

R: How do you think you got there? Was there anything you were thinking about when you decided that that wasn't an option?

P: I guess just the not being in a place to want to go through that in my life at that time, not wanting people to find out, and just knowing that I needed to just sort of get out of the situation as quickly as possible [primary appraisal- made decision quickly].

To get through this time she focused on “the life I was supposed to have,” and said this helped her to not change her mind about the abortion.

During the Abortion

Allison did not speak about the actual procedure, except that it was very helpful that two friends accompanied her [resource- friends]. She was not really prepared for the procedure, and was shocked when they did a sonogram [environmental constraint- not enough information]. The most memorable part of the experience was going through the picketers at the clinic.

R: How about society, what did you feel their views were about abortion?

P: I think society is pretty – you know, there are some people that are pro-life, some people that are pro-choice, and it just depended where you went. I mean I definitely got a picture of society, you know, when I drove up to the clinic and those people were standing outside, you know, with signs that said, “You murderer,” and things like that. I mean that was a scary picture of society [environmental constraint- picketers].

After the Abortion

Allison reported that not only did she feel relief after the procedure, but also guilt. She said that one of the results of going through this is that she examined her beliefs, and now realizes she is pro-choice [reappraisal- realized pro-choice views]. This also

allows her to be less judgmental and understanding of others in her situation. She said she does not believe that she fully thought of the impact it would have on her life, or that it might come up later. She stated she does not know if she has truly coped with the abortion, especially since feelings about it sometimes sneak up on her [**reappraisal-abortion did affect her life**]. She did mention the abortion to a counselor, but they never spent much time discussing it. She believes she may not know what impact it has had on her life at the present time.

P: Well, yeah, I mean I wish I had thought about it or, as in the terminology that's in all like the papers, is I wish I had actually coped more afterwards, instead of just sort of going, doing it, and then just sort of like pushing it down and not dealing with it.

R: What would coping have looked like for you?

P: If I look back on it now, I would have loved to have gone to some sort of counseling or therapy or something like that, just to deal – to fully deal with it, you know. I mean they talked to me for like three minutes beforehand, but nothing – nothing in depth, I mean. And going to some sort of therapy or counseling wasn't how I dealt with things then. Which is I do that more so now, and if I had to do it over again, or whatever, I would probably do some sort of counseling, more than the three minutes before where they ask you, "Are you sure you know what you're doing?"

R: If you had gone to counseling, what would you have considered as a successful, I guess, outcome?

P: I mean I probably would have still gone through with it, but I think just making me talk about it and deal with it and realize, you know – I don't know, I think saying it out loud and actually dealing with it, instead of just going, doing it, and not thinking about it for two years afterwards or – you know, would have been successful to me. Because I don't regret having done it, I just think I could have – it wouldn't surface in, you know, certain ways now in my life if I had dealt with it then.

Although the previous section gave examples of the theoretical constructs that were being studied, the following section directly addresses the research questions:

- (1) Discover and describe the relevant primary and reappraisal processes the women went through
- (2) Describe the problem-focused and/or emotion-focused coping strategies
- (3) Describe the resources the participants felt were helpful
- (4) Identify any personal or environmental constraints to coping
- (5) Draw conclusions and comment on differences, if any

Primary Appraisal

When faced with unplanned pregnancies, all of the women appraised the situation as stressful. More specifically, they all appraised the situation as a threat. Kristen and Margie saw the pregnancy as a threat to their education. Missy, Geri and Allison all saw the prospect of a pregnancy as a threat to the careers. Not only did Kristen see the pregnancy as a threat to her education, but also viewed it as a threat to her relationship with her parents. Joan did not view the pregnancy as a threat to her career, but saw the possibility of a disabled child as a potential threat to her current family life and marriage.

It is clear from this that all of the women in determining what was at risk were focused on their future and how the decision to keep or abort the pregnancy would affect the outcome.

As part of the primary appraisal process and determining what was at risk, all of the women except Margie described making the decision to terminate their pregnancies rather quickly. Margie was the only one who gathered information from various sources, and took time to look at the information she had gathered. She did, however, state that although this gave her assurance about her decision, a negative aspect of taking a longer time period was a more complicated and painful abortion procedure. Missy, Geri, and Joann all described purposefully limiting who they spoke with and what information they exposed themselves to during the primary appraisal process. They described that this made the decision- making process easier for them.

Emotion-focused Coping

Missy, Joan and Kristen all described using avoidance to get their minds off the abortion. Missy used substances as well as sex to help her to not think about what had occurred. Joan described burying herself in books and family life, while Kristen described staying very involved with her schoolwork. This form of coping was also evident before and during the abortion in which participants were distancing themselves from the abortion. They did this not only by avoiding information about the abortion, but also by distancing themselves from anything they did not believe would support their decision.

Problem-focused Coping

Missy described her initial coping as using substances as well as sex to cope with the abortion. She later described adopting a healthier lifestyle after her recovery. Part of her present coping is nurturing herself on a constant basis. She describes this as eating right and doing activities that make her feel good about herself.

Missy, Joan, and Margie all described sharing their experience with others to cope. Missy singled out sharing her experience with other women as her most important coping mechanism. She works with women who are considering or have had abortions. She is able to be non-judgmental, and reports that helping others has been essential to her personal coping. Joan shared the experience with her two older daughters in a teaching capacity. Margie also shared her experience with her two children from a teaching standpoint. She also supported two friends that had abortions, and found it very helpful to share her experience.

Margie reported that talking with others, crying, and praying also helped her through the period of time after her abortion. Joan also reported that praying was helpful to help her cope with some of her feelings after the abortion. In addition to prayer, Joan reported that the Lamaze breathing she learned with her first three pregnancies has always been helpful to her during times of stress.

Resources

The women I interviewed expressed many different things that they considered resources through the entire process. The most common resource the women described was their female friends. Four of the participants described confiding in and depending on the support they received from their friends. Missy identified her family as a resource.

Geri saw her parents as her main resource after the procedure. Margie found her mother's support essential to planning and carrying out the procedure. Geri and Joan described their current husbands as resources as well as their ob-gyn physicians. In addition to family, Missy identified her religion as well as AA as important resources. In addition to her mother and friends, Margie identified a priest and her boyfriend as resources. Kristen viewed the kind woman that stayed with her through the procedure as an important resource.

Personal Constraints

Since Missy, Geri, Margie, and Allison all had backgrounds in Catholicism, they viewed their internalized religious beliefs as impeding their coping. This however was much different than the women's spirituality, which many of them found as a source of comfort. Most were anxious about telling their parents about their abortions. All except Allison chose to share this information with their parents and found them to be supportive. Allison has chosen not to share the information with her family because of her fears about how they might respond due to their strong pro-life beliefs. Geri described avoiding her gut instincts as a personal constraint.

Environmental Constraints

Joan, Margie and Allison each expressed that parts of the procedure were very stressful for them. This was mostly the case because they lacked information about the procedure that would prepare them for what they might see, hear, and feel. Joan was shocked by the sound of the suctioning device. Margie was not aware that they would dilate her, inject saline, and then deliver the fetus. Allison was not prepared for the sonogram, which they performed before the procedure began. Allison also expressed that

she was not prepared for the picketers surrounding the clinic. She stated that this was the only time she doubted her decision.

Reappraisals

The most common reappraisal which was discussed by Missy, Geri, Margie, and Allison is that they realized they could not control the impact that the abortion had on their lives. They felt that they would be able to contain any feelings or thoughts associated with the abortion. When they reappraised the experience they realized that it had a much larger impact on their lives than what they had predicted. Margie and Allison also explained that they reappraised their views on abortion once the topic personally affected them. They both thought they were pro-life before they discovered their pregnancies, but realized they were not. Joan expressed that she thought after the procedure that she might have been cowardly for taking “the easy way out.” And Missy reappraised her whole lifestyle to get to the place she is today. She also currently viewed the abortion as killing a child. She believes that if she had seen it that way when she discovered the pregnancy she would have never had the abortion.

CHAPTER FIVE

CONCLUSION AND DISCUSSION

As many as 1.5 million abortion are performed each year in the United States and research related to these women's experiences of the process of making the decision is limited (Butler, 1996). This study begins to fill that void by describing the entire abortion process including primary appraisal and reappraisals, coping and constraints on coping efforts, as well as resources for six women who participated in the study.

This study used a stress and coping model designed by Lazarus and Folkman (1984) to design questions to understand how women appraised and coped with having an abortion. The participants were recruited through the use of flyers posted at several Northern Virginia businesses and educational facilities. They were asked about their experiences from the time they discovered the pregnancy to the present. They were also asked about family beliefs and relevant background information. The participants shared the information pertaining to the questions asked and any other information they believed was relevant for them.

Many commonalties and themes emerged among the participants' interviews. All of the participants in making the decision to abort, appraised the pregnancy as stressful. They all saw the pregnancy as a threat to either their future plans or relationships with family. Most of the participants limited whom they spoke with or what information they exposed themselves to in order to make the decision easier for them. All of the women believed before the abortion that it would be a short-term stressor, and that it would have little, if any, effect on their lives. For all the participants except one, this has not been the case, and they reappraised it to be much more profound and long term stress then they

had believed. All of the women described using some form of avoidance as a form of coping and many described sharing their experience with others. The resources the women described included their family, friends, and ob-gyn physician. Personal constraints were most often described as internalized pro-life values from their family of origin. Environmental constraints in all cases were that they were not given enough information, not only about the procedure itself, but also about longer term emotional effects. Overall, all participants except one said they would most likely make the same decision given the same circumstances, and all participants reported that they felt they were coping well.

Several of the findings were supported by the literature. In their research, Eisen and Zellman (1984) found that 82% of their participants would make the same decision when faced with an unplanned pregnancy. In my study five out of the six participants would have also chosen to abort under the same circumstances. In making the decision, Hendricks-Matthews (1983) found that women under 18 years of age took longer to make a decision about the outcome when faced with an unplanned pregnancy. This was also true for the one participant in the study who was 18 when she discovered the pregnancy. The same participant also had distress for about two weeks after the abortion, which Kaltraider (1979) states can be related to second trimester abortions. Some distress may have also been related to internalized religious beliefs, which Osofsky and Osofsky (1972) suggests can produce more guilt and difficulty in making the decision. One of the findings for all the participants is that they were coping well given a stressful life event. Cozzarelli (1993) and Mueller and Major (1989) both found that participants with high

self-efficacy coped better. This may have been true for my sample, because they all had the belief that they could control the impact of the abortion.

Implications

The information gained in this study was obviously important to the participants because all of them expressed an interest in reading the findings of the research once it was completed. It may be helpful to women who have had abortions to read other's experiences to see that they are not alone in their experiences and feelings. Finding commonalities through reading other's stories may be similar to one of the ways that many women coped by sharing their experience with others. In addition to women who have already had abortions, women contemplating abortion may also find the research helpful to see what experiences others who have chosen abortion have had.

These findings could also be enlightening to health care workers to help women be prepared not only for the procedure itself, but also any emotional issues afterward. Of the participants in my study, four felt unprepared for the procedure itself, and were shocked by some of the happenings. Although many of the abortions were performed many years ago, the findings would be helpful to encourage implementing more education around the procedure to ease tension for the women.

This research might also assist mental health clinicians to understand these women's experiences. Although I have not yet had the opportunity to work with a client who has had or is considering abortion, I would definitely share my findings with them to give them a range of the women's experiences. If I felt that it was appropriate, I would also allow them to read my thesis so they could get a more detailed description of the findings, so that they could hear the voices of the participants. In reading what the

women said in their interviews, it would also be helpful to understand they felt supported by supportive persons. This would assist clinicians or anyone else helping a woman through the abortion process understand how to be a support, so that the woman would be more likely to talk about their experience freely. Another clinical implication is that two of the participants brought the abortion up while seeking therapy for other issues. During both occasions, the participants felt that the abortion issue was not dealt with. While reading findings such as these, it may help clinicians to examine their own feelings regarding abortion that may impede working with women who have had abortions.

As a clinician myself, this research has greatly affected what I think about abortion, as well as how I would work with a woman who has had an abortion. Going into the research, I was surprised by the number of women who had abortions in the U.S. annually. Most surprising to me was that I knew of very few women personally or professionally who had talked about having abortions. I knew based on the research regarding the number of women who have abortions, that more women I came into contact with must have had or know of someone who had an abortion. This surprised me because in my personal and professional life, people often talk about very personal issues, but the abortion issue almost seems taboo.

I had written a short research paper several years earlier about abortion, which sparked my interest, especially due to the varying findings in the literature. I must admit that when I picked the subject for my research topic, I do not believe I was fully cognoscente of the political nature of the subject matter until several colleagues responded with comments about how brave I was to research the topic of abortion. Although I thought I was very comfortable with the topic, classifying myself as non-

judgmental, but pro-choice, I must admit I found myself a little anxious telling those I did not know well about my thesis topic.

I had not anticipated the depth and honesty that was evident from these women's stories. I think, for whatever reason, I had expected more simple stories that fit neatly into my theoretical constructs. It is from these women's stories that I have realized not only what a complex issue abortion is, but also the secrecy that surrounds the issue itself.

Limitations

The clinical implications of this study are limited by the sample size, limited demographic characteristics, lack of random sampling, no control group, and retrospective data collection. There were only six women interviewed about their abortion experiences. Of these six, all were Caucasian except one. These women, although varied in age, had the financial resources to access the health care of their choice. Although the goal of the study was not to assess women's level of coping, I viewed all participants as "successfully coping" with the abortion. For example, all were gainfully employed, had established functioning lives, with no obvious impairment of overall functioning.

Random sampling, no control group, and voluntary participation limit the generalizability of these findings. The previous limitations are, of course, limitations of the majority of qualitative research, since it is designed to give a greater depth of individual's unique experiences. This population of women is difficult to reach, and was therefore limited to those who would respond to flyers posted at "neutral" locations (no pro-life or pro-choice locations). This study was not expected to be generalizable to all

women who have abortions. It did however attempt to develop an understanding of the experiences of those women who participated in my study.

Another limitation is that participants are sharing their views retrospectively. It is possible that one may not accurately recall the events and their responses. It is possible that their views are influenced by the several years and life experiences that separated them from the abortion experience. However this may have produced a more retrospective view and given more weight to reappraisals. The intensity of emotions may no longer be relevant, but several participants stated they could recall many of the events with clarity.

Another limitation was the subject matter itself as well as the stress and coping theoretical model. Due to the strong societal beliefs surrounding abortion, the literature itself shows a strong discrepancy in its findings, which may possibly be due to differing agendas. Little research states any biases of the researchers, so it is difficult to determine what literature should be given more merit. Due to this my research is based on literature with a broad range of findings, which may be subject to the researcher's belief systems. In addition, the stress and coping model which I used to interpret my findings is another limitation. It was clear after conducting the interviews that not all the constructs discussed fit into specific theoretical categories. The advantage of using the model was that it gave me a guide to follow in writing my interview questions as well as structure to the results. It did however limit the information I collected as well as limiting the interpretation of the findings.

Future Research

This research covered a very wide range of topics that were relevant to the stress and coping model used. Each topic: primary appraisal, reappraisal, coping, resources, personal and environmental constraints has the possibility of being studied individually. Each one of these topics contains enough information to be studied more in depth. The goal of this research was to get an overall picture of the entire process the women went through. Each topic could be researched individually to get a more detailed scope into each individual processes.

In addition, since only the women were interviewed, the research could be expanded to include the process from the viewpoint of the women's partner, resources, clinic staff, and families. Anyone who had a part in helping the woman through the process could be investigated to see their viewpoints on the process. Their perspectives could also be compared with the women obtaining the abortion. Another sample of women who considered abortion, but chose to keep the pregnancy could also be investigated to see how their processes varied from the women who chose to abort.

Summary

The goal of this paper was to understand more about the entire process women go through in the decision to have an abortion and how it affects them. Given all the many issues that surround this decision, I chose to use a stress and coping model to interpret the findings. Each of the women shared with me in great depth their unique experiences and perspectives on a stressful life event. Although there were many commonalities among their individual stories, each of them had a unique perspective to tell. The results leave me feeling hopeful about the resiliency of these women, because although all of them

described some part of the part of the experience as stressful, they have all found ways to cope with their abortions.

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Appendix A

Participant's Informed Consent

Title of the Study: Coping with Abortion

Investigator:

This study is being conducted by Christa Moscovis Denny, candidate for a master's degree in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Christa can be reached at (703) 518-7364. Faculty advisor, Dr. Sandra Stith, can be reached at 538-8462.

I. Study Purpose

- The purpose of this study is to understand women's appraisal processes before, during, and after an abortion. Interviewing women five to ten years post abortion will also allow us a retrospective view of their coping mechanisms.

II. What Will I Have to Do?

- Fill out Informed Consent and a demographic information sheet.
- Participate in an interview and answer questions about your abortion experience. The interviewer will focus the questions around the evaluative processes and coping resources you used.
- The interview will take about two hours.
- The interview will be tape-recorded and typed for analysis.
- You will be contacted to see if you would like to review the typed interview to clarify any mistakes.

III. Benefits of this Project

- You will be helping others who have had abortions as well as clinicians to understand the important aspects of the decision- making and coping processes.
- Hopefully, the findings will be helpful to those making a decision or who have had an abortion and clinicians in working with female clients where abortion is an issue.

IV. Is it Private?

- The information you share will be treated as completely confidential.
- Only the researcher/interviewer and her faculty advisors will have access to the information you share.

- Your name will be removed from all transcriptions, and will be replaced with a fictitious name. The list that allows a link between the taped interview and demographic data will be kept under lock and key.
- Your name will not be used in any documents produced as a result of this study. Every effort will be made to change any information that might allow someone to identify you.
- At the completion of this study, all raw data that has been collected will be destroyed.
- If you share information that leads the researcher to believe you are in danger of doing harm to yourself or someone else, the researcher must take steps to protect you or others.

V. Risks

- You may on occasion find it uncomfortable to discuss certain parts of your abortion experience. You will not be asked to discuss any issue that causes great discomfort or which you are not willing to discuss.
- You may decline to answer any question. The interview will be terminated at any point at which you are no longer comfortable proceeding.
- All participants will be given a referral to an experienced therapist at the conclusion of the interview if they wish to get therapy for any issues brought up during the interview.

Compensation

- If requested, you will be sent a summary of the project's findings upon its completion.

Freedom to Withdraw

- If at any time you change your mind about participating in this study, you are encouraged to withdraw your consent and cancel your participation.

Participant's Agreement and Responsibilities

- I have read and understand what my participation in this study consists of. I know of no reason that I cannot participate in this study. I have had all my questions answered and hereby give my voluntary consent for participation in this project.
- If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.
- Should I have questions about this research I will contact:

Christa Moscovis Denny (703) 518-7364 Researcher/Interviewer

Dr. Sandra Stith (703) 538- 8462 Faculty Advisor

Dr. H. T. Hurd

(540) 231-5281

Chair of the Virginia
Tech IRB

Participant's Signature

Date

Appendix B

Demographic Questionnaire

1. Current Age _____
2. Age when abortion occurred _____
3. Approximate length of pregnancy when you found out you were pregnant _____
4. Approximate length of pregnancy when abortion occurred _____
5. Were you married or had children when you experienced the abortion?
6. Are you currently married? Number of children _____
7. Your ethnicity: Caucasian, African American, Asian, Hispanic, or other _____
8. Current religion _____ Religion at the time of the abortion _____
9. Highest degree of education: Elementary education, High school graduate, College graduate, Master's or doctoral degree.
10. Degree of education at time of abortion _____

Appendix C

Questions for Interview

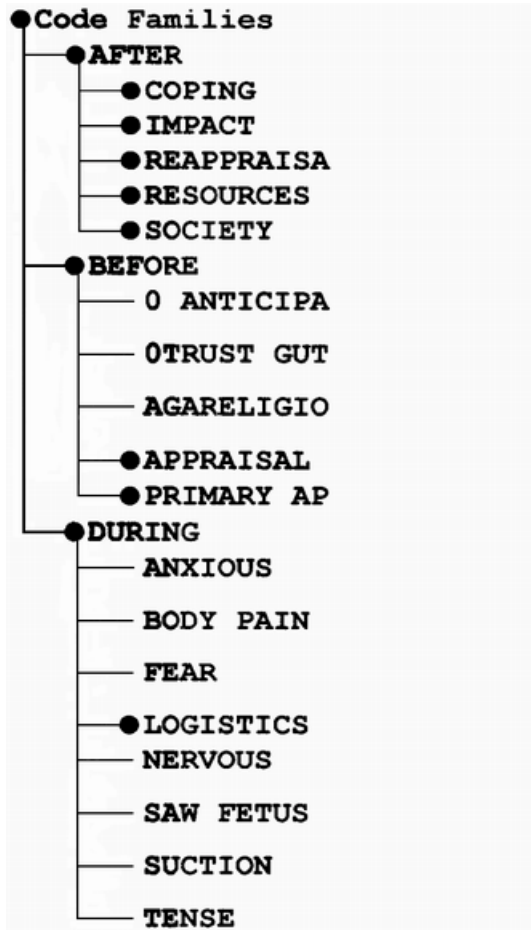
The interview will begin with the researcher requesting that the participant share with me what they feel it would be important for me to know or understand about their abortion experience. Depending on how much depth the woman goes into will depend on whether the researcher needs to use the following questions as means of eliciting information or clarifying what the participant has shared. The following questions will be used as a guide to cover information in the following areas.

1. How did you decide what options were available to you in making the decision to abort?
2. What if anything kept you from exploring alternate options? What do you think your response may have been to exploring other options?
3. What strategies did you apply to make the decision? Did they change over time?
How?
4. At the time prior to the decision-making what were your beliefs about abortion? What were your family's/friend's/society ideas about abortion?
5. How confident did you feel that you could control how much the abortion impacted your life?
6. What did you predict would be your response to the abortion?
7. What implications did you see as a result of the abortion in the future?
8. What emotions did you encounter in making the decision, during the procedure, and afterward? Did they change? When?

9. If you experienced any emotions what did you consider your resources to help deal with them? If you did not seek out any resources, what kept you from doing so?
 10. What did you think about to help you make the decision, during the procedure, and afterward?
 11. How would you rate your level of stress before, after, and during the procedure? If any level of stress changed to what would you attribute this change?
 12. What do you think may be the difference between someone who experiences abortion as stressful versus someone who does not?
 13. What did you identify as your resources (both personal and environmental)?
 14. How were the resources helpful to you?
 15. What would you have done differently, if anything, to access more or different resources?
 16. What helped you to cope/adjust/make it through a stressful time?
 17. Did you identify any personal or environmental constraints on your ability to cope?
- Overall, how would you assess or rate you abilities to cope?

Appendix D

Abbreviated Family Tree



Appendix E

Posted Flyer

1 out of 5 women's lives are touched by abortion

Researcher at Virginia Tech's Northern Virginia Center is seeking women 18 or older who are at least 5 years post-abortion who would be willing to share their experiences.

Please Call 703-518-7364
(Voice Mail is Confidential)

Christa A. Moscovis Denny

Education

Virginia Tech, Falls Church, VA

M.S. in Marriage and Family Therapy, August 2001

- Coursework includes clinical and theoretical study in systems theory, marital and family therapy, ethics, human sexuality, child and family development, research methods, and statistics.

Mary Washington College, Fredericksburg, VA

B.S. in Psychology, May 1996

- Coursework for major included Statistics, Abnormal Psychology, Learning and Motivation, Personality, Forensic Psychology, and History of Psychology.

Relevant Experience

Couple's and Men's Domestic Violence Prevention of Virginia Tech, Falls Church, VA

Facilitator (Therapist), 2000- present

Teach 12 week Men's anger management and 16 week couple's group to domestically violent men and women. Goals were to prevent any further episodes of violence, and present new skills for non-violent living.

Center for Family Services, Falls Church, VA

Family Therapist Intern, June 1998-2000

Provide psychotherapy to families, couples, adults, adolescents and children with a wide range of mental health issues.

Family Teamwork - Wrap-Around Homebased Services, Centreville, VA

Homebased Specialist, June 1996-present

Provide intensive counseling and mentoring services to children, adolescents, and their families who are experiencing problems in the home and community. Services include: advocacy, role modeling, life skills training, intensive supervision, responding to family emergencies, and implementing individualized family plans.

Snowden at Fredericksburg - The Center for Mental Wellness and Recovery, Fredericksburg, VA

Mental Health Technician, 1996-1998

Assisted patients in the adult psychiatric unit with daily living chores and activities associated with their recovery. Gained information about numerous psychological disorders ranging from alcohol dependency to psychotic behavior. Maintained order on the unit through verbal intervention and/or non-violent restraint techniques. Developed and led group therapy sessions, in addition to one on one contact with assigned patients.

Fairfax County Department of Human Development, Fairfax, VA

Volunteer/Facilitator, 1994-1995

Acted as a volunteer facilitator for the Nurturing Program. Used a group therapy approach to work with children and their parents to reduce abusive behavior, teach appropriate developmental levels, expectations and discipline, and build positive interactions. Assisted administratively by preparing visual aids to help teach program lessons.

Hugh Mercer Elementary School, Fredericksburg, VA

Volunteer/Teacher's Assistant, 1992-1994

Aided kindergarten students with various activities, especially students with behavioral problems, and helped the teacher in all aspects of classroom management. Attended to the specific needs of students with Attention Deficit Disorder, who required more structure and supervision.