CONCEPTION, PREGNANCY, DECISION MAKING, AND POST ABORTION RESPONSE AMONG WOMEN WHO HAVE UNDERGONE SINGLE, REPEAT AND MULTIPLE VOLUNTARY FIRST TRIMESTER ABORTIONS

by

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Abstract

Conception, Pregnancy, Decision Making and Post Abortion Response Among Women Who Have Undergone Single, Repeat and Multiple Voluntary First Trimester Abortions

by

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This dissertation investigated first trimester voluntary abortions of women who underwent multiple procedures. The abortion experience was described as three interdependent contexts. The conception-pregnancy context was the period subsequent to the perceived conception and prior to the decision making process. Variables included were pregnancy ambivalence, intendedness and wantedness of the pregnancy, pregnancy attribution, and maternal motivation. The decision making context included social and personal beliefs regarding abortion, and partner support and influence on the decision. The post abortion response context, included negative and positive feelings, grief, and post abortion syndrome.

Recruited from urban undergraduate colleges, subjects were divided into three groups; 39 women who had one abortion (single aborters), 11 who underwent two abortions (repeaters), and 21 women who experienced 3 or more abortions (multiple aborters). Subjects were given a questionnaire to do privately, and returned it to a

designated location at their campus. In addition, 8 multiple aborters were interviewed.

There was minimal statistical support to distinguish the multiple aborter group. In the conception-pregnancy context, multiple aborters were more likely to attribute their pregnancies to chance, when compared to a combined single and repeater group. Single and multiple aborters experienced greater ambivalence towards the pregnancy than the repeaters given their higher net maternal motivation scores. In the decision making context, statistical significance was approached by repeaters who had the lowest scores on "pro-life" subscales. This suggests that single and multiple aborters experienced greater ambivalence towards the abortion procedure, given their higher "pro-life" attitudes. The three groups did not differ in post abortion responses. Consecutive multiple aborters (at least three consecutive procedures) attributed their pregnancies to their own behavior, and were more likely to incorporate partner's influence in their decisions.

This study determined multiple abortion is not a separate phenomenon in terms of the abortion experience, and decision making strategies. Despite minimal findings, women's health care professionals frequently bestow negative judgements toward multiple aborters often leading to pathological diagnosis. It is suggested that laypersons' and professionals are subject to social influence consisting of the vacillating social attitude towards abortion. It is recommended that professionals monitor their biases which impede upon treatment.

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INTRODUCTION

Statement of Problem

There is a growing population of women, who have had the experience of undergoing several therapeutic or voluntary abortions. In 1976, 18% of those women who had an abortion had a second procedure, by 1985 this figure increased to 35% (Landy and Ratnum, 1985). When abortion methods improved and abortion was legalized many political groups became concerned that the use of other birth control methods would decrease. Thus, the increase of repeat abortions was misperceived by some as an indication that women were using abortion as a method to control their fecundity (Tietze, 1978). Contrary to these beliefs, it has been demonstrated that: "There is no evidence that the availability of abortion has led to the abandonment of contraception or relaxation of contraceptive vigilance" (Steinhoff, et al., 1979, p. 30). Research has shown that access to abortion did not decrease contraceptive use, and that many women used abortion in addition to contraception in order to postpone earlier or later births (Hern, 1984).

Given the professed concern, the vacillating political climate, and despite the aforementioned evidence, it is often assumed that women who have had several abortions are consciously using the abortion procedure as their favored and primary birth control technique. There is an implicit assumption that women undergoing multiple abortion procedures are willing to have abortions, despite the fact that research demonstrates otherwise (Berger, et al., 1981). This assumption ignores the fact that abortion is often

the end result to an unwanted pregnancy. The woman is often in a state of crisis, due to an event that she did not expect or may not have wanted to happen. Also overlooked, are the possible underlying psychological issues surrounding the pregnancy and the socioeconomic context which may limit or prevent some women from making a full and independent decision regarding their reproductive choices.

While working in an abortion clinic, a women's correctional facility, a college, and a female adolescent psychiatric unit, I was confronted with many women who have undergone several voluntary abortions. Since contraception was technically simple and non-life threatening, I found myself wondering why these women would undergo several procedures, given the supposed availability of contraception. One could see how the assumption of the abortions as a preferred birth control method was readily made. Yet, during actual conversations, most of these women stated that abortion was not their personally chosen birth control choice. Many had used it as a last resort, in the aftermath of an unplanned pregnancy. The question arises, since contraception is generally less physically invasive, less costly and more socially acceptable, why were these women left with only their last resort on several different occasions? What was their decision making process regarding the pregnancy and the abortion? Had their prior experiences of abortions influenced their decision regarding subsequent pregnancies and abortions? Was there something different in the cognitive processes or the psychological state following their abortions that led these women to undergo multiple procedures?

Many of my immediate supervisors in the various clinics commented critically on the quantity of abortions some patients had undergone. They judged it as added

symptomatology or diagnostic in terms of pathology. Little was done to understand or investigate the issue for itself. These women continue to be perceived as careless and immature by professionals and laypersons. Kenyon (1986) suggests that multiple abortions may be a response to three possibilities: "restitution for the aborted fetus, neurotic need to become pregnant, or a healthy reaction to a changed circumstance (p. 191)." Were multiple abortions indicative of a pathological character, or were they a poor adaptive response to certain circumstances that were currently occurring in the woman's life?

While working in an abortion clinic, I was exposed to different strategies used in the training of counselors. For example, we were instructed to never use the words 'baby' or 'child'. Instead such terms as 'tissue', 'fetal matter' and 'pregnancy' were utilized to refer to the pending procedure. Was this negation of the outcome of the pregnancy beneficial to these women, or was this contributing to the confusion or ambivalence that may exist for the women who have multiply aborted? Using terms such as fetal tissue removed the prospective notion of a baby. It removed any possible suggestion of "life," presumably to make the procedure easier for some women. Additionally, we were never allowed to discuss the decision with the woman. The notion was that it is a private decision that should not be influenced by staff. Staff felt that this lack of discussion concerning her decision was the best way to convey respect for the woman's choice. Some women may have wanted validation for their choice, or for their current confusion, and this may have been gone neglected by staff.

Yet, most of these women thought of life futuristically in terms of not being able

to care for or raise a child. A primary reason for undergoing an abortion was because they felt that an infant and child had the right to be wanted and loved, and their current circumstances did not allow this (Burnell & Norfleet, 1987). I observed that most women regardless of the number of procedures expressed an array of feelings throughout their ordeal, which is consistent with current research findings (Burnell & Norfleet, 1987). Prior to surgery, most women were apprehensive and fearful, yet felt their decision was necessary and the right one. After the procedure the women reported feeling relieved often vowing never to repeat this situation. Yet many expressed guilt and sadness over their loss. The ambivalence seemed very disquieting and was a common complaint expressed during the post operative examination. No woman, ever expressed the desire to repeat the procedure, and professed it as their new birth control method.

The key question that arose then was the notion of preference, and whether there is a conscious decision made to use abortion as a preferred birth control method. That is, is the abortion her first choice of birth control as opposed to the last available alternative? In the case of those women who had undergone several procedures, why is she left with only the last available alternative?

Definitions

The nomenclature regarding womens' reproductive terminology is often confusing due to the use of different definitions depending upon discipline, e.g., public, legal or medical. For example, most lay people understand abortion to be the medical termination of a pregnancy, when the medical field defines abortion as any type of termination of pregnancy including miscarriage. To avoid confusion, provide clarity, and to remain

consistent, a list of definitions is provided below (Williams, et al., 1989).

1. **Abortion: termination of pregnancy by any means before the fetus is sufficiently developed to survive. In the United States this definition is confined to the termination of pregnancy before 20 weeks gestation based upon the date of the first day of the last normal menses**[1]

2. **Spontaneous Abortion: An abortion which occurs without any mechanical intervention to terminate the pregnancy. Also referred to as miscarriage by laypersons.**

3. **Therapeutic Abortion: Termination of pregnancy before the time of fetal viability for the purpose of safeguarding the health of the mother.**

4. **Voluntary Abortion: The interruption of pregnancy before viability at the request of the women but not for reasons of impaired maternal health or fetal disease.**

5. **Dilation and curettage: Method of termination of pregnancy consisting of the dilation of the cervix and then evacuating the products of conception by mechanically scraping out the contents. Usually performed during the first 16 weeks of gestation.**

5. **Dilation and evacuation: Method of termination of pregnancy consisting of the dilation of the cervix and then evacuating the products of conception by vacuum aspiration (suction curettage). Usually performed during the first 16 weeks of gestation. This is the preferred method, due to less risk of perforation or infections, it is quicker, and less blood is lost.**

6. **Second Trimester Abortion: Termination of pregnancy occurring after the second trimester. When medically induced other methods are used such as intraamnionic hyperosmotic solutions (saline abortion), administration of oxytocin, etc.**

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[1] This dissertation will refer to abortion and first trimester voluntary abortion interchangeably, which is similar to public usage.

7. Single aborter: **For the purpose of this study a woman who has had only one voluntary first trimester abortion.**

8. Repeat aborter: **A woman who has undergone two voluntary first trimester abortions. Often referred to as "recidivist" in several disciplines.**

9. Multiple aborter: **For the purpose of this study, a woman who has undergone three or more voluntary first trimester abortions.**

10. Nulliparous: **Never having giving birth to a child.**

11. Multiparous: **Having borne more than one child.**

12. Viability: **a reasonable potential for subsequent survival if the fetus were to be removed from the uterus. Although there is some variability in the medical literature, this is estimated at less than 20 weeks gestation and less than 500g in weight.**

The most common types of voluntary abortion are dilation and curettage (DC) and dilation and evacuation (DE), this is because "89% of all abortions are performed within the first 12 weeks of gestation (Costa, 1991, p. 91)." The greatest number of abortions for one woman recorded was a prostitute in Brazil who had 29 procedures ("Repeat Abortions," 1989). Research has led to the distinction in the literature of the terms; single aborter (first abortion); repeater or recidivist (second procedure). One can recognize the covert value judgement in the word "recidivism" which is the terminology used to delineate those women who have had more than one abortion. Recidivism is defined as "an individual who repeats the same delinquent acts or criminal offenses for which he [sic] was previously treated or punished" (Rosen, 1954, p.41).

Hafez (1984) found women were more likely to repeat an abortion in the year

subsequent to their first abortion. Similarly, Leach (1977) found that 56% of repeaters in his sample had their second abortion within the first year, due to contraceptive failure. Gibb and Millard (1981) report a 15 month interval between first and second procedures, while Jacobsson, et al., (1976) found a two year lapse. Tietze (1978) found the average interval between two procedures is 27 months. The second abortion may be a result of the woman using a new contraceptive method after perceiving the failure of a former contraceptive method led to the first abortion procedure. Due to contraceptive inadequacy, and her own inexperience with the newly selected method, she is at greater risk for contraceptive failure.

Women who have had three or more abortion procedures, may have other psychological factors involved that cause them to end up with their only available recourse: the abortion. Little research is available on the multiple aborter or higher order aborter, but she has generally been defined as someone who had three or more procedures (Tietze and Bongaarts, 1982). This definition is limited since it ignores many possible intervening variables such as time element, the inability to account for different levels of failure in contraceptive technology, and human error in contraceptive application. Berger, et al., (1981) found the average time between procedures for multiple procedures to be 3.3 years, with the average gestation period of 8 weeks. Somers (1978) found the average interval between abortions for repeaters was 207 days (a little less than 7 months), while the average length of time between three procedures for multiple aborters was 175 days (a little less than 6 months). The question arises as to whether this one month is significant. Are women who have had consecutive procedures experiencing something

different from those who have had intermittent procedures? This paper proposes that the multiple aborter is in some way distinct from the repeater. For example, there may be different psychological factors at work for the woman who has undergone three consecutive abortions, as opposed to the woman who has had two procedures 5 years apart as a result of contraceptive failure. Another issue is when the procedures were done. Women who have had abortions prior to the 1973 Supreme Court decision were more likely to have had a different experience such as little or no counseling, less information and below standard medical care (Schneider & Thompson, 1976; Tietze & Bongaarts, 1982). Abortions prior to 1973 were done in a different social context, thereby leaving women more ashamed and less available for research inquiries.

This paper will continue with the presentation of the findings that have been already established in the literature with respect to single and repeat aborters, with the understanding that it is limited when discussing the multiple aborter. Women with two first trimester voluntary abortions will be called repeaters, and women with one procedure will be referred to as single aborters. For the purpose of this study the multiple aborter will be defined as women who have had three or more first trimester voluntary abortions. Only those women who had their procedures subsequent to the 1973 decision will be considered.

LITERATURE REVIEW

Social, Historical and Political Ideology

Although much of the rhetoric surrounding the original Roe v. Wade controversy suggests that therapeutic or voluntary abortions are a phenomenon of modern times and moral decay, references to abortion have existed for thousands of years (Imber, 1986; Kenyon, 1986). Throughout history women have been trying to control their parity through the use of herbal medicine, ritual sacrifice, coat hangers, peroxide, and currently, through the most common surgical procedure done in the world (Kenyon, 1986). While statistics vary, it is estimated that 1.5 million voluntary abortions are performed annually; this translates to 27.4 abortions for every 1,000 women between the ages of 15-44. Worldwide, this amounts to 30-40 million legal abortions annually, with an estimated 20 million illegal abortions performed annually (Dagg, 1991).

Therapeutic and voluntary abortions have either been accepted or rejected. This acceptance or rejection is both a public and private issue. "The changes in fertility (delayed and decreased child bearing) and reproductive technology has affected all peoples' ideas on the meaning of children and childbearing within the family and in society (Pritchard & Thompson, 1982, p. 127)." Contraceptive technology and availability, economics, religion and culture are all factors that contribute to social attitudes and governmental policy regarding the practice of abortion (Kenyon, 1986). For example in China where IUD's are the dominant form of contraception, abortion is a standard procedure mandated by the government. Abortion is then incorporated into the culture as a form of population control and child spacing, if other available methods of

contraception have proven ineffective (Li, et al., 1990). Pressure to terminate a pregnancy is applied through economic, financial and social sanctions.

Abortion as a vehicle for family planning is reflected in the relationship between fertility patterns and economic structures. In developing countries that are less literacy dependent and rely on agricultural resources, women often seek abortions once they have achieved their necessary family size. In industrialized nations women are more likely to have abortions prior to starting families (World Health Organization, 'WHO'. 1979). This finding was demonstrated on a microlevel in several studies which found repeaters to be either educated nulliparous women attempting to delay their families and uneducated repeaters who were multiparous trying to maintain their current family size (Smith, et al., 1983; Steinhoff et.al., 1979).

Another factor influencing the acceptance of abortion is the availability of contraceptives (Tietze & Bongaarts, 1982). For example, in Russia, Poland, and most of Eastern Europe the contraceptive supply is severely limited. Abortion is often the only available birth control. Thus abortion is readily available. It is common for women to have a minimum of 5-8 abortions (Kenyon; 1986; New York Times, February, 1989;). In countries where abortion is legalized and accepted, one should expect to see an increase in the number of repeaters. Research in England and Japan suggests that the more the procedure is accepted, within the culture, the more likely multiple abortions will be accepted and resistant to social ridicule (Brewer, 1977). This is congruent with Landy and Ratnum (1985) who concluded that the rate of repetition is much higher in industrialized countries where abortion is a socially accepted procedure than in those

developing countries where abortion is still highly criticized. For example, in Hungary where abortion is a primary source of birth control, 49% of the women can be defined as repeaters. In contrast to India where abortion is socially unacceptable, there is a 6% repetition rate.

Another aspect of birth control, which dovetails with the topic of abortion are contraception methods, specifically their effectiveness rates. Many investigators have concluded that two abortions are often a result of contraceptive failure and not lack of contraceptive availability (Bolognese & Carlson, 1977; Gibb & Millard, 1981; Howe, et al., 1979; Rovinsky, 1972; Steinhoff, et al., 1979). Tietze (1977) stated that 55 out of 1000 women will repeat an abortion due to contraceptive failure, based on a coital frequency of three times a week. Skjeldestad & Bakketeig (1986) found that of those women using the pill (99% effective rate) 15.7% will experience an unwanted pregnancy within 5 years of their first abortion; those women using an IUD (98% effective) 29% will experience an unwanted pregnancy within 5 years of their first abortion. Tietze (1976) estimated that among those women who use a contraceptive method with a 99% effectiveness rate, approximately 39.5% will repeat abortions; those on 90% effective contraception, 75% will have at least a second abortion. Tietze's figures are higher because he is looking at a woman's entire reproductive history, which he estimates as a range from age 15 to 44. To conclude, repetition is primarily due to the fact that contraception is not 100% effective.

Figures on repetition rates vary, depending upon location and time of the study. Between 1972 and 1986 repetition rates have range between 5%-30% (Brown, 1979;

Freeman, et al., 1980; Gibb & Millard, 1981; Jacobsson, et al., 1976; Kenyon, 1986; Rovinsky, 1972; Steinhoff, et al., 1979;). Skjeldestad & Bakketeig (1986) found that women were three times higher at risk for a second abortion than of having an initial procedure. It has been shown that as the level of the overall abortion rate increases so will the percentage of repeat and multiple abortions (Berger, et al., 1984; "Repeat Abortion," 1989; Tietze & Bongaarts, 1982 Jain, 1978; Tietze & Jain, 1978). In essence, the risk of repeating an abortion is either greater or equal to the risk of having the procedure initially (Tietze, 1978). He also found that the rate of repeat abortions will level off after a period, subsequent to legislation and social acceptance. They note that when Hungary legalized abortion in 1956, initially the rate of repeat and multiple abortions increased. By 1960 the rate stabilized. Skjeldestad & Bakketeig (1986) also found this leveling off phenomenon. They interpret it as an indication that women are not using abortion as a contraceptive method, otherwise the rate of abortion would continue to increase. In addition the leveling off phenomena reported by Tietze (1978), also occurred in the United States. In 1976, 18% of those women who had an abortion subsequently had a second procedure. By 1985 this figure increased to 35% (Landy and Ratnum, 1985). This increase has leveled off according to Costa (1991) who reports only a 3% increase by 1987. Osofsky and Osofsky (1973) saw repeat abortions as inevitable due to a woman's age, rate of coitus, fecundity, contraceptive failure and contraceptive availability.

As for isolating the multiple aborter from the repeater, the delineation is difficult. Statistics tend to replicate the increase seen in repetition rates, with a leveling off at

approximately 5%. Steinhoff, et al. (1979) found in his sample of 16,961 women that 15.5% had one prior abortion; 12.7% had two procedures; 2.3% had three abortions and .4% had four procedures; .06% had five; and .03% had 6 abortions. In a Canadian sample of 580 multiple and repeat aborters 72% had one prior procedure; 23% had two prior abortions and 5% had three or more (Berger, et.al., 1984). Tietze and Bongaarts (1982) found that from 1974-1978 the number of women in the United States who have had three voluntary abortions increased from 1.9% to 5.1% (17,110-71,860). Women who had four abortions climbed from .8%-2% (6,850-27,740). In a study of 403 medical records of women who had abortions between 1975-1980 Heinrich and Bobrowsky (1984) found that 313 women had prior abortions; 15.9% (62) had one abortion just one year prior to the abortion reviewed for the study; 45.4% (183) had one previous abortion at some time in their life; and 16.9% (68) had at least 2 previous procedures. In 1987, 1.5 million abortions were performed. Of these 42.9% were a second abortion; 26.9% were third abortions; 10.7% were fourth abortions and 5.3% were fifth or more abortions ("Repeat Abortions," 1989). The above statistics indicate that in a one year period, of those women who will undergo an abortion, 75,000 will undergo at least their third procedure.

Although the above statistics are occasionally contradictory, overall they support each other. The contradictions and variations in results may be due to research methodology, human error and the effect of different social and cultural forces. In essence, how women interpret their understanding of contraceptive technology, in terms of their individual biology, but in their thinking and behavior regarding contraception, will

influence abortion rates. What is demonstrated from the above research is the notion that the probability of a woman repeating an abortion is not an indication of pathology, but rather a highly probable phenomenon within the normal probability range. As stated previously, the distinction between a multiple aborter and a repeater is less clear when the definition is based on a differential of two and three abortions. What is noted from above is that the percentages are slightly higher for a multiple aborter (5%), than for a repeater (3%). Others have also noted an increase in the number of multiple aborters as opposed to the number of repeaters (Steinhoff, et al., 1979). While the selection of three abortions may be an arbitrary one in terms of defining the multiple aborter, this 2% increase translates to 30,000 women. The research is clear on the repeater resulting from contraceptive failure and human error. What is not clear is the explanation of what subjects a woman to undergo three, five or six procedures.

In 1973, the United States established abortion as a woman's constitutional right. Nevertheless, the topic has continuously remained highly controversial. The precarious state of this issue has often been contingent upon elected administrations, and the political climate they exude. In addition, the constant fluctuation in ideology has influenced the individual woman's personal beliefs. Nonetheless, the number of abortions performed have steadily increased since the 1973 legalization, despite some periods of governmental and group efforts to reverse the Supreme Court decision. Likewise, the number of women seeking their second abortion continues to rise (Gibb & Millard, 1981).

The abortion patterns noted above in developing and industrial countries have been paralleled in the United States. That is, women of higher economic status typically

have repeat abortions prior to starting families. In contrast, women of lower economic status and minority women are more likely to repeat abortions after they have attained their preferred family size (WHO, 1979; Bracken, et al.1972). Due to the pending debate and criticisms surrounding abortion despite its legality, and given the availability of contraceptives in the United States, the phenomenon of having more than one abortion procedure, is seen as highly pathological, warranting studies by several investigators. However, Tietze and Jain (1978) concluded:

> An increasing proportion of repeat abortions among all legal abortions and a repeat abortion rate substantially higher than the first abortion rate should not be interpreted as indicative of moral decline or a decrease in the practice of contraception (p. 297).

One would expect multiple abortions to occur in the United States given the previously stated findings that there is an increase in repetition rates in those countries where the procedure is legal and accepted, and, there has yet to be available a completely effective contraceptive method. In the United States the acceptance of abortion is tentative at best, which is due in part to the controversial and unsettled social debate that continues to surround the issue. Rather, repeaters and multiple aborters are judged as being unconcerned with moral and ethical issues, and guiltless ("Repeat Abortions,"1989).

What is noted is the reticent quality surrounding abortion in general, and multiple abortion in particular. In fact women are less likely to report their illegal and multiple abortions, when being interviewed (Heinrich & Bobrowsky, 1984; Skjeldestad & Bakketeig, 1986; Tietze & Bongaarts, 1982; Tietze & Jain, 1978). Women are often ashamed of having to resort to an abortion, and fear ridicule. Kenyon (1986) points out

"that women often fear contempt, censure, rejection or hostility from their doctor" (p.163). Given this social aspect, the repeater or multiple aborter is in a more precarious and scorned position, often forced to hide the number of procedures she has undergone (Gibb & Millard, 1981).

Women's Experience of Abortion and Contraceptive Behavior

Women who have abortions

Efforts have been made to establish the demographics or the "type" of women who have abortions. Costa (1991) reports that abortions are more common among unmarried, childless, catholic Whites, with the average age being 25. Biasco and Piotrowski (1989) found that college educated women had more positive attitudes towards abortion, and were more willing to utilize abortion as a pregnancy resolution option. Research has not demonstrated that there is one age that is a major factor in multiple abortions (Aguirre, 1980; Berger, et al, 1984; Bracken, et al., 1972; Somers, 1977; Tietze & Bongaarts, 1982). Overall, most studies have concluded that no singular set of specific demographic or personality variables are prototypical of women seeking an abortion (Cahn, 1976; Gibb, 1984; Kenyon, 1986; Tsoi, et al., 1987). However, these conclusions do not extend themselves to women who have undergone several procedures.

In the attempts to describe and analyze the behavior patterns that may lead a woman to have more than one abortion, many comparative studies have been done. Researchers have often compared women going for their first procedure (single aborters) to women going for their second procedure (repeat aborters), with little attention to the women undergoing three or more procedures (multiple aborters). For example, Berger,

et. al., (1984) makes no distinction between women who have had two or five abortions and places them in the same experimental group in his Canadian sample.

Much of the literature regardless of discipline, has indicated negative conclusions and interpretations regarding the personalities of women who have had multiple abortions. Some judge the repeater and multiple aborter in negative terms finding pathological concommitants, while others have found the repeater to be a victim of statistical probability, and organizational and contraceptive technological inadequacy (Berger, et al., 1984; Howe, 1979; Steinhoff, et.al., 1979; Tietze, 1978; Tietze and Jain, 1978). Leach (1977) looked at the attitudes of women who had undergone a repeat abortion. He found these women considered themselves victims of bad luck, and felt a greater need to change themselves in response to the second abortion. Rovinsky (1972) described repeaters as having some motivation to be pregnant, but showed no evidence of major psychiatric or psychological disturbance.

Many view women who have had more than one abortion as maladjusted, or irresponsible with respect to contraceptive use. That is, they suffer from contraceptor failure; not using their contraceptive method correctly (Gibb & Millard, 1981). Callan (1983) found married repeaters were more likely to use the pill, but half the women in the sample felt that their pregnancies resulted from their own risk taking behavior regarding contraception. Single aborters reported risk taking contraceptor behavior in terms of being unprepared contraceptively for sexual activity, yet, doctors often view the repeater as "irresponsible and assume a punitive attitude in their treatment" (Bolognese & Carson, 1977, p.51), often under the assumption that the woman has opted for these

procedures. The implication is that although abortion is available, it is considered a one-time procedure despite of the fact that there is no completely effective contraceptive available other than sterilization or abstinence.

Smith, et al. (1983) compared medical files of repeaters and single aborters in order to develop a profile for women "at risk" for undergoing more than one abortion. These authors found repeaters were more likely to wait longer (more than 11 weeks) before the abortion which often resulted in a different procedure (prostaglandin drip), while single aborters were more likely to be less than 11 weeks gestation. Repeaters were less likely to go for a required follow-up examination. Repeaters were also more likely to use their general practitioner rather than a clinic or gynecologist for follow-up examination. The authors infer that repetition may be a result of the lack of specific information given by general practitioners in the areas of contraception and abortion. These physicians may not be specifically trained in women's reproductive health and may be imposing a value judgement due to their lack of training. Berger, et.al. (1981,1984) found repeaters were more likely to be educated, married and have children. In contrast, Hafez (1984) found single women were more likely to repeat the procedure more, and being single was the primary reason for their first procedure. Thompson and Robinson (1986), found several differences between single aborters and repeaters. Repeaters had more education, a greater frequency of intercourse.

The research presented on repeat aborters appears contradictory and confusing. Research on abortion often comes from different disciplines such as public health, psychiatry, medicine, social work and psychology. These disciplines often have different

theoretical orientations and methodological approaches. For example, psychology will focus on individual differences, while public health researchers investigate health issues and trends en mass. The different theoretical orientations may contribute to differences in the definitions of abortion. For example, many studies included subjects who had different types of abortions (saline, voluntary and medical abortions). Subjects were also from different countries, which may result in different attitudes on abortion and different contraception practices.

In terms of investigating the multiple aborter, Brewer (1977) found approximately 10% of his sample of multiple aborters to be professional women. He also found that multiple aborters have a greater history of erratic contraceptive use, a prior history of psychiatric consultations, and have a history of unsettled relationships. Similarly, Kenyon (1986) reports that multiple aborters had a high incidence of erratic contraceptive use, and a greater number of psychiatric consultations. Much of the literature on repeat and multiple abortions is inconclusive, when culture and age are investigated. This may be due to a lack of clarity in definition, and the impact of the social climate of the particular group under investigation. Studies which looked at women from Scotland, Sweden, United States and Singapore found repeaters and multiple aborters were more likely to be married with children, claiming the abortion was the least desirable option (Freeman, et al., 1980; Horobin, 1973; Jacobsson, et al., 1976; Tsoi, et al., 1987). Somers (1977) found repeat aborters in Denmark fell in the age bracket of 20-34. He felt that younger and older women were less likely to repeat abortions due to less frequency in intercourse and reduced fecundity respectively. A direct inverse was found in an American sample;

Bracken, et al., (1972) found a curvilinear relationship in a study of repeaters; either very young or older women had repeat abortions, and most report using contraception at the time of conception. Tietze & Bongaarts (1982) and Tietze (1974) found that women in their late teens and early 20's had a higher rate of repeat abortions, and the rate decreased as women's ages increased. They explain that women older than 31 were less likely to undergo multiple abortions, since there is a decrease in fecundity and a tendency for women to carry to full term. In contrast, Berger, et al., (1984), found repeaters to be significantly older (mean age; 27) as compared to single aborters (mean age; 24). Aguirre (1980) also found repeaters to be older and more educated. Gibb and Millard (1981) explain that older women were more likely to repeat the procedure because they have a longer exposure to unprotected intercourse. The above indicates there is no conclusive evidence that age or culture are dominant contributing factors in the explanation of why women abort.

Certain psychodynamic theorists attribute repeat abortions to unspecified unconscious dynamics that serve as a motivator regarding a woman's parity. An extreme example of this is described; "... these women are performing a purification ritual involving anal expulsive behavior" (Gibb, 1984, p. 584). Fisher (1986), drawing upon clinical experience, suggests repeat abortions are due to a need to repair an infantile developmental failure, particularly separation and individuation. The woman is acting out those difficulties experienced with her family of origin, which repairs the narcissistic injury caused by inconsistent maternal nurturing during the preverbal state. She bases her theory on Abernathy's (1973) work which found repeaters' parents were more hostile with

each other. Mothers were viewed as unloving and non-sexual, and fathers are described as passive, idealized, and magical. The abortion serves as the route in becoming independent of this system.

Pines (1990) suggests that women may have goals other than motherhood when they become pregnant. Pregnancy is often seen as a validation of one's femininity, maturity and sexuality. The state of pregnancy is often an unconscious reminder of a woman's negative relationship with her own mother, so the woman aborts in order to eliminate the negative feelings. Pines continues by citing a single case study of a woman who had three voluntary abortions had a very conflictual relationship with her own mother. Not only did each abortion end the relationship with the conceptor, but each procedure was an unconscious use of her body to seek revenge against her dominating mother.

Gibb and Millard (1981) report that repeaters come from unloving homes, specifically with unloving, non-supportive mothers. Object relation theorists El-Mallakh and Tasman (1991) cite a case study of a multiple aborter who is also bulimic. In addition she is diagnosed as borderline personality disorder with a major depressive episode. They describe the use of the body as a transitional object in terms of the patient unconsciously trying to fuse with the omnipotent maternal object. Unconsciously this is rejected, which is then manifested in the purging or aborting. Consciously, the bulimic takes food in during states of extreme anxiety. The food is found to be psychologically soothing. She would then purge when aware of the caloric consequences and physical discomfort. By comparison, the multiple aborter finds the sexual intercourse and

pregnancy calming, inevitably the pregnancy produces anxiety and discomfort, which then causes the woman to abort.

Personality Types of Women

Several studies have looked at personality variables, albeit little distinction is made between repeaters and multiple aborters. Multiple aborters and repeaters are described in some of the literature as having a poor self image and more impulsive on personality measures. They were found to have tendencies toward depression, and psychosomatic illnesses, were psychologically immature, less likely to consider consequences, and had a lower frustration tolerance, (Jacobsson, et al., 1976; McGraw, 1989; Rovinsky, 1972). Gibb (1984) looked at locus of control among multiple aborters (repeaters were included in the study), hypothesizing that these women were more impulsive and believed that their situation was due to external factors, rather than an internal control. His findings revealed the opposite. Repeaters viewed themselves as low on impulsivity (similar to nulliparous women), and locus of control varied amongst all groups. Gibb then concluded that the abortion may have been viewed as a positive learning experience used to avoid future pregnancies. In contrast, Thompson and Robinson (1986) found no differences in locus of control or self concept between repeaters and single aborters. Berger, et.al., (1984) found no difference between single, repeaters (multiple aborters were included in his definition of repeaters) on personality tests. All results fell within the normal range. In contrast, others found multiple aborters had a greater likelihood of experiencing suicidal ideation, personality pathology, and depression ("Repeat Abortions," 1989). It is unclear if these symptoms were a result of the multiple

abortions, or possibly a predisposition towards psychopathology prior to the multiple procedures.

Relationship with Conceptor

When looking at women's experience of repeat and multiple abortion little is available with respect to the conceptor's contribution to the experience. Traditional methodology has tried to isolate single variables such as contraceptive knowledge and availability, which places the issue entirely on the woman. Aguirre (1980) suggested that since many women aborted as a result of their marital status the relationship was worth further investigation:"The centrality of man-woman relations is necessary for an understanding of repeat abortion behavior, and the need to orient future work on repeat abortion away from a predominant concern with contraception (p. 275)."

Research on the quality of the heterosexual relationship and its impact on abortion is conflicting. Tsoi, et al. (1987) found that repeaters and multiple aborters reported less marital satisfaction in his sample of Singapore women. Berger, et. al. (1984) reported the same in his Canadian sample, although these women reported a greater frequency of intercourse than single aborters who reported greater marital satisfaction. Multiple aborters were less likely to be living with their partners. Brewer (1977) found those women with erratic contraception use were more likely to be in unstable relationships. Several researchers have found that women with more than two abortions were less likely to be married, had relationships of shorter duration, and were more likely to be divorced, separated or widowed (Heinrich and Bobrowsky, 1984; "Repeat Abortions," 1989). These authors concluded that unstable relationships increase the risk for repeat and multiple

abortions. Reportedly, there is a negative correlation between the number of abortions a woman has and the quality of the relationships, for each conception. For example, one subject was married during her first abortion, her second resulted from an extramarital affair. Her third and fourth procedures were from short casual sexual encounters. From this, the authors concluded "that partners of repeaters took less responsibility for contraception even though the women had left them greater responsibility in that respect" ("Repeat Abortions," 1989, p. 4).

Overall, the research suggests that the factors that differentiate women who have had one abortion from those who have had two are circumstantial and are due to contraceptive inadequacy, and not to underlying psychodynamic issues. There is evidence to indicate that there is an association between the relationship with the partner and number of procedures. The quality of that association is not clear. As the above literature reveals, there is still continuing controversy with regard to isolating specific personality variables that distinguish repeaters from single aborters. Findings are further complicated by studies that collapse the repeater and multiple aborter into one category. As a result, there is a lack of knowledge and information about women who are defined as multiple aborters.

Cognitive Decision Making

Classical Theory

Classical decision making theory is based on mathematical models with an economical framework in terms of gains, losses, probabilities, which yield monetary values involving cost benefit analysis (Bourne, et al., 1986). The Expected-Utility Model

of decision making has dominated the literature, and has been modified in order to extend beyond the notion that the best decision is that which nets the greatest monetary gain. In its' simplest form: the value of each alternative is multiplied by the probability of that alternative occurring. Thus, the alternative with the highest probability and value is the choice decided upon by the individual. Each alternative is evaluated by weighing its levels of pleasure or pain, the end result is the expected utility. It is expected that the alternative with the highest utility is the obvious choice. Abortion when defined by classical theories is a deliberate and active decision, which falls under the notion of task oriented decision making (Bourne, et al., 1986). Clearly, classical decision making theory is limited when discussing the choice of abortion, in that it isolates the decision making process from the social context that surround the individual's alternatives. In addition, the Expected Utility Model asserts that optimal decisions are made with much time and effort (Bourne, et al., 1986). Abortion is often decided while the woman is in crisis, and always under a limited time span (Stotland, 1991).

Components of the decision making process in the abortion experience will be described, in order to identify those aspects unique to the experience. Following this description, sociocognition theory is suggested as a more viable explanation in determining the underlying process of decision making in abortion.

Contraceptive Decision Making

The link between contraceptive choice and abortion is evident, since the latter often results from a problem with the former. In addition, attitudes and use of contraception are positively correlated with attitudes and use of abortion (Faria, et al,

1985). Smith, et. al., (1983) questioned women after their abortion during their follow up examination. They found that childless single and repeat aborters were equally likely to request the pill as the preferred contraceptive method. However, multiparous women regardless of the number of procedures, were less likely to request contraception. Others found no difference in contraceptive patterns of repeaters and single aborters (Berger, et.al., 1984; Skjeldestad & Bakketeig, 1986). Campbell (1990) found as the number of abortions increased for a woman, so did the probability her using contraception. In contrast, Tsoi, et al., (1987) and Jacobsson, et al., (1976) found repeaters and multiple aborters used less reliable methods of contraception, and were inconsistent in their regulation of those methods, yet were more knowledgeable about contraception than single aborters. Siimilarly, Faria, et al., (1985) found that women who were less likely to use contraception were more likely to wind up in an abortion clinic. The authors interpreted these results as women feeling they have little right to control their own body. Steinhoff, et.al. (1978) suggested that social and personal factors affect upon contraceptive practices indeed resulting in repeat and multiple abortions. In a classic study of 1,505 women who have had at least two abortions, Howe, et. al, (1979) found that women going for their second abortion were more likely to have been using contraception at the time of their second conception, than those who were going for their initial procedure, and denied using abortion as a contraceptive method. Thompson and Robinson (1986) also found that repeaters were more likely to be using contraception at the time of conception, and concluded that repeaters were those women for whom contraception was less likely to work. These findings were similar to those collected in a Swedish sample (Jacobsson, et

al., 1976). Gibb and Millard (1981) also found repeaters were more likely to be using contraception. Others have suggested several reasons for a second procedure are contraception inadequacy, tendency to be at a more fertile age, greater sexual activity, difficulty in obtaining contraception, and more sporadic contraceptive use (possibly in response to first abortion) (Hern, 1984; Leach, 1977; Schneider & Thompson, 1976; Tietze, 1978). Brewer (1977) studied women in England who had 3 or more abortions. He reports similar findings to those studies addressing repeaters: abortion was not considered the preferred contraceptive technique; the primary reason for the third abortion was due to contraceptive failure; and most of the women were single. Multiple aborters had a much more erratic use of birth control. Erratic failure was defined as either the withdrawal method, or at least one unprotected intercourse between the second and third procedure.

The various findings regarding contraceptive use, may in part be due to differences in definition. For example, the studies cited are not specific in terms of distinguishing between contraceptive method failure and contraceptor failure.
In addition, individual attitudes towards contraception are often molded by the social attitudes and hence availability of contraception within a group. Some of the contradictions regarding contraceptive use among aborters cited in the research may not reflect a difference among aborter groups, rather may reflect the social sanctions and thus availability of contraception within a culture. Little is known about the impact of social factors on a woman's contraceptive reproduction decision making.

Decision Making in Abortion

There are only three available choices for a woman regarding an unwanted pregnancy: continue the pregnancy with intended adoption; continue the pregnancy and keep the child; or, elective abortion. Many variables affect a woman's decision to have an abortion. Sociologically government opinion, contraceptive availability, and the role and status of women within a culture are a few of the macrosystems which influence her decision. For example, Faria et al., (1985) found women of color felt more positive than caucasian women about their decisions to abort. Lemrau (1988) reports that the mixed message of the sociocultural environment in which a woman makes a decision about abortion will reinforce any ambivalence that she may be having. Reasons considered traditionally acceptable by most cultures also influence her decision: the woman's health and sexuality, if she was raped, or the likelihood of genetic or congenital defects in the fetus (Kenyon, 1986; Lemrau, 1988; Westoff & Ryder, 1977). On an individual level, career, marital and financial status, religiosity, quality of relationship, family size, age, concept of physical and psychological pain, length of pregnancy, personal definition of life and its inception and fetal viability and her attitude about abortion will all be contributing factors in her decision process (Aguirre, 1980; Berger, et al., 1984; Biasco & Piotrowski, 1989; Callan, 1983; Faria, et al., 1985; Kenyon, 1986; Osofsky & Osofsky, 1972; Turell, et al., 1990).

On a personal level, the emotional context as well as the individual circumstances surrounding the pregnancy will affect the decision regarding pregnancy outcome (Adler, 1975; Bracken, et al., 1978; Faria, et al., 1985). This refers to the degree of wantedness

of the pregnancy and intention to get pregnant. Miller (1980) explains that the "intendedness" of a pregnancy happens prior to conception, and is defined by the degree that a woman or a couple plans or avoids a pregnancy. Whereas the "wantedness" of the pregnancy occurs after conception, and is the degree of how wanted or unwanted the pregnancy or child is. Women can have different degrees of wantedness and intendedness of a pregnancy, depending upon individual situations. In addition, the feelings about the desire to get pregnant and the desire to continue the pregnancy and rear a child are not simplistic or dichotomous, but may vary from pregnancy to pregnancy, and may vacillate during the course of one specific pregnancy. If a woman is experiencing incongruent states between her intention to become pregnant and the wantedness of the pregnancy, then she is experiencing ambivalence towards the pregnancy. Miller (1980), describes another aspect ambivalence with respect to intention as "when the individual has sufficiently strong doubt and counter-motivation that the strength of intention varies considerably over time (p. 1)." This author continues by describing types of psychological and behavioral ambivalence: subintention is defined as when an individual has little or no subjective experience of intention, but their beliefs and feelings suggest an acceptance of, and even an interest in the event and their behavior exposes them to a considerable increased risk of its occurrence. It has been found that if a woman has ambivalent feelings about the pregnancy, it may cause a delay in her decision about the pregnancy (Peppers, 1987). Although a woman's belief in abortion will contribute to her decision, it does not have to be congruent with her own personal decision to abort, should she find herself in the crisis of an unwanted or unintended pregnancy. The author of this

dissertation, hypothesizes that even though a woman decides to have a voluntary abortion, she may go through different degrees of intention and wantedness, prior to the actual procedure. In the case of the multiple aborter there may be a greater degree of ambivalence in the intentionality and wantedness of the pregnancy.

The above information reveals that women who have undergone multiple abortions do make contraceptive decisions and use contraception. The literature hints at behavioral and cognitive factors that may distinguish those who have had three or more procedures from those who have had less. Berger, et al. (1984) and Bracken, et al. (1972) described repeaters as less anxious in their decision to abort for the second time. Leach (1977) concluded that although repeaters were less anxious about the actual procedure, they experienced more guilt due to having a second procedure. Tsoi, et al. (1987) and Berger, et.al. (1984) found that single aborters, repeaters, and multiple aborters indicated similar reasons for having abortions; their families were complete, or they were child spacing (creating temporal space between births).

Partner's Involvement in the Decision

Often the decision to abort is not made in isolation, rather it is determined within the social context of a relationship, or amongst a group of intimate friends or family. Stone-Joy (1985) felt that the relationship with the conceptor was a crucial component of the decision making process. Miller, (1980) points out that a woman's wantedness of a pregnancy is often influenced by her partners wantedness of the pregnancy. He further describes ambivalence in the intention of getting pregnant is often resulting when another person essential to the decision is in opposition of the woman's decision. Peppers (p. 9,

1987) suggests that if a woman has a strong external locus of control, and thereby highly influenced by her partner's attitude, she may become filled with ambivalence and anxiety. The ambivalence results in a tendency for the woman to isolate herself, and limit herself from the influence and social support of others (Peppers, 1987).

Little is understood in terms of how the quality of the relationship with the conceptor/partner, and how the dynamics of the relationship may influence a woman's decision. Despite this, it has been found that the male partner has a very large role in shaping the pregnancy resolution, especially in ongoing relationships (Marsiglio & Menaghan, 1990; Stone-Joy, 1985). For example, one could speculate that the conceptor is participating in these repeated pregnancies as a way of marking his own virility, and she may be thinking that he is very concerned about her needs. Another possible scenario may be the woman becoming pregnant without his knowledge or agreement, maybe as a way of solidifying the relationship. Turell, et al., (1990) notes that if the relationship was a casual, women found the decision to abort much easier. The converse was also reported; if the conceptor were a spouse or a fiance, the decision to abort was a more difficult one. Campbell, et al., (1988) found older women were more coerced by their partners to abort. These authors found in a comparative study of young and older women undergoing abortions that both groups were more aware of their parent's marital difficulty, and reported a more chaotic personal life than non-aborters. One could conclude that these women are more aware of the environment, and fear the implications of raising a child in such and environment, or that the abortion itself can be traumatic to the relationship.

The partner or conceptor in the relationship has been investigated in terms of support and the decision making process with little distinction made upon the number of abortions (Major, et al., 1990; Turell, et al., 1990). Major, et al (1990) found no difference between repeaters and single aborters in terms of who they told about the abortion. Additionally, they found that perceived support from the partner was more important than his actual physical presence at the abortion clinic. Lester & Cook (1988) found in a college sample that the number of abortions due to chance and was not related to a sense that the subjects were being controlled by significant others. Bracken et al., (1972) and Berger. et. al. (1984) found the partners of repeat aborters were less involved in their birth control choice and decision regarding the abortion. Many repeaters reported less solidarity with their partners ("Repeat Abortions," 1989). Berger, et al., (1981) found repeaters were more likely to make the decision alone without consulting the conceptor, despite a greater frequency of intercourse using less effective methods of birth control. These researchers concluded that a woman is more likely to undergo abortions if her relationship is perceived to be poor in quality. Aguirre (1980) in an interesting study looked at the relationship between marital status and repeat abortions. The author found certain predictive relationships between specific variables underlying the repeated procedures and the woman's marital status. It was found that girlfriend's support and birth control methods were predictive of single women who had two or more procedures. Birth control failure was the predictor for divorced repeaters, and for married women the predictor was religion. Aguirre argues that since women had different variables linked to their multiple procedures based on marital status, then women's relationships worth

researching.

Implications of Sociocognition Theory

Sociocognition research is a plausible explanation for the process of how women will incorporate the assistance of others, specifically their partners in the pregnancy resolution process. These theorists suggest that people pool information from their social context in order to execute their decision, believing that this pooling of information is more complete than an individual decision based solely on their own information (Hastie & Pennington, 1991). Researchers in sociocognition who look at decision making in group settings such as a jury, suggest that most individuals make up their mind prior to deliberating with the group. Albeit that individual's decision is subject to influence and change due to the social interaction during jury deliberation.

When defining the social context of the pregnancy one could substitute the relationship underlying that conception and compare it to the group, and the quality or type of relationship analogous to the social interaction. Indeed, most women do discuss their decision with someone, usually the partner, mother, friend, or physician (Faria, et. al., 1985; Marsiglio & Menaghan, 1990). One could therefore assume that the discussion and input of the partner's opinion and the quality of the relationship does impact upon the individual woman's individual pregnancy resolution. Kenyon (1986) gives the example of the putative father may have coerced the woman into having an abortion, literally against her will, and eventually the woman felt that it was the better decision. One could then hypothesize that some women are more likely to rely on their partner's decision, especially if she is experiencing a large degree of ambivalence during the crisis

of an unintended or unwanted pregnancy.

The initial individual decision making process according to sociocognition theorists, consist of ". . . the individual attempting to make sense of social events by pooling information (Hastie & Pennington, 1991, p. 310)". In the context of pregnancy decision making, the woman will consider the quality of the relationship with the conceptor, her family, income, and her career. Based upon the pooled information the individual will develop several narrative stories with different possible outcomes, eventually settling on one overall narrative story or outcome. This final narrative and outcome will then influence her and become her final decision. This is a form of reasoning. Individuals, when alone will reason in a fashion that is congenial to sharing with others, in the hopes that their decision and the underlying narrative is congruent with the opinions of those with whom they share their decision. These individual narratives which are congruent with others' opinions are perceived as social support. Hence, words, while the individual is making that initial personal decision, they are still thinking in reference to a social context and the narrative of that social context. In the case of the aborter's reasoning and decision making process, the relationship defines the social context.

Wilson (1986) suggests that when a male partner's provides a negative influence on a woman's own personal goals, this can have damaging effects. I surmise that women who are ambivalent about their pregnancies and their resolutions, are more likely to seek their partner's opinion (his underlying narratives) to help make the decision, thereby perceiving this as social support. If the decision made through the influence of the

partner is incongruent with the individual personal decision of the woman, then the woman may be more likely to change her narrative to fit his, in order to feel supported, and to remove the ambivalence. This incongruency in the reasoning process will leave a woman more susceptible to undergoing multiple abortions. That is, the conflict between the personal and relational decision making regarding abortion as the solution to the unwanted pregnancy, will produce psychological distress.

To summarize, there were no reliable statistically significant trends between multiple aborters, repeaters, and single aborters with regard to contraceptive use and choice. Some researchers indicated that multiple aborters were more likely to use contraception. One could assume, that these women are more knowledgeable and aware of health and contraception, thus leaving them with more available options. Others note other psychological differences, the erratic contraceptive user compared to the consistent user had significantly more psychiatric consultations prior to this third procedure. "While repeat abortions are often the result of repeated contraceptive failure, repeat abortions among women who erratically use contraception should create curiosity for the clinician (Lemrau, 1988, p. 465)." Research has demonstrated that male partners impact upon the decisions that women make for themselves, although many women choose to deny or are unaware of that influence (Wilson, 1986). Male partners do impact upon contraceptive and abortion choices as well. Clearly, when in a relationship each member takes on certain roles and tasks. These roles do have an effect on the other member (Hastie & Pennington, 1991). These different roles and tasks do affect the decision making process surrounding abortion. Depending upon the nature of her relationship, for many women

there may be no choice in the matter; when they look at the alternatives to abortion their choice to abort may be the dominant one, in that it is superior to other alternatives (Bourne, et al., 1986). For example, many women are influenced by a partner who refuses to become involved in the pregnancy. They see no other alternative other than abortion since they perceive their partners as unsupportive. Clearly decision making processes and partner's influence upon those processes amongst multiple aborters requires further investigation.

Post Abortion Response

Whether or not a psychological reaction process exists subsequent to an abortion is under much debate and correlated to the political climate surrounding the procedure's acceptance (Wilmoth, 1992). That is, when abortion is under much political scrutiny, then researchers depending on their political position will either suggest no severe reactions, or the converse which would be the suggestion of an actual psychiatric disorder occurring as a result of an abortion. This same political climate will also affect the individual's emotional response post procedurally. A woman's reaction to the abortion cannot be separated from the influence of the cultural climate in which it happens (Turell, et al., 1990). Speckhard & Rue (1992) suggest that what is defined as post abortion reaction is the normal response to abortion and not indicative of pathology. These authors further suggest that it is the politicization of abortion that has led to the pathological inferences rather than the recognition of what may be a normal reaction. As a result these authors refer to a continuum of psychopathology stemming from a more severe form of the normal post abortion reaction referred to as "post abortion distress" extending to "post

abortion psychosis" which is more consistent with current psychiatric diagnostic criteria.

Nonetheless, the psychological reactions following an abortion have as its foundation a woman's cultural and religious beliefs, the social and political stigma encompassing abortion, and beliefs surrounding the inception of life (Adler, 1992; Biasco and Piotrowski, 1989; Corsaro & Korseniowsky, 1983; Kenyon, 1986; McGraw, 1989; Olley, 1985; Peppers, 1987; Turell, et al., 1990). Post abortion reactions are also affected by the moral sanctions against pregnancy outside of marriage and against abortion, that are within her culture (Goada & Ruark, 1984; Major, et al., 1990; Olley, 1985; Wilmoth, 1992). On an individual level; current life stressors not associated with the pregnancy or abortion; the length of gestation; a woman's self-efficacy, emotional expressiveness, and perceived social support will impact upon her post abortion adjustment. A woman's prior parity will affect a woman's response to abortion. Turell, et. al., (1990) found women with children tend to cope better following an abortion than women who are nulliparous. In addition, how intended and how wanted the pregnancy of the current abortion will impact upon the subsequent psychological reaction (Adler, 1992).

It has been difficult for researchers to agree on one definition of post abortion response. Most women having a first trimester abortion have it on an outpatient basis or in a free standing clinic. The procedure is performed by a physician who will probably not know her, nor is the physician trained to diagnose psychological problems thus, is less likely to refer her to counseling (Stotland, 1985). In addition, those women who are experiencing the greatest degree of psychological discomfort are more likely to seek professional services, and gynecologists are more apt to refer only those women with the

most obvious and severe symptoms. Some believe that post abortion reaction may present itself years later lasting several years (Speckhard & Rue, 1992). Thus, researchers disagree on the severity, duration, and the time of presentation of post abortion reaction, making it difficult for clinicians and researchers to recognize it. The question remains for clinicians and researchers remains unanswered, it is unclear to classify post abortion reaction as a psychiatric disorder or is it a normal consequence following an abortion. Also under debate is what places a woman at risk for the post abortion reaction; the abortion procedure itself, or the social context surrounding the abortion. Nonetheless, most researchers agree that there are some women who do experience negative consequences following an abortion (Wilmoth, 1992).

Positive Effects

Several researchers suggest a positive psychological experience, a sense of relief, following an abortion (Adler, et al., 1990; Burnell & Norfleet, 1987; Hafez, 1984; Horobin, 1973; Lemrau, 1988; Osofsky & Osofsky, 1972; Turell, et al., 1990). Neubardt and Schulman (1977) found that most women feel a sense of relief and emotional "washout" (p. 41) after the procedure, primarily due to the heightened anxiety prior to the decision, and over the pending procedure. These positive reactions are more probable if the pregnancy was both unintended and unwanted (Adler, 1992). Adler (1975) reports that time is an important factor. She found that the mild to moderate feelings of guilt and regret were often experienced immediately after the procedure, and feelings of happiness and satisfaction with the decision to abort increased over time. Osofsky and Osofsky (1972) report that of their sample, 98% of the women said they would undergo the

procedure again rather than go through an unwanted pregnancy. Horobin (1973) found more distress among women who were denied the procedure. Najman, et al., (1991) questioned mothers 6 months after they were denied an abortion, and then compared to women who had an abortion. Those women who were denied the procedure had higher rates of anxiety and depression.

Post Abortion Reaction (PAR)

The normal post abortion reaction may include contradictory emotions, this may reflect in the mixed feelings that many women experience, and is part of normal stress and coping (Adler, et al, 1992). Adler (1975) notes that it is quite possible to feel a multitude of feelings, including those that oppose each other such as regret and happiness; ". . . although a woman may terminate a pregnancy, the pregnancy may not have been totally unwanted (p. 449)." Burnell and Norfleet (1987), in a retrospective study found that 50% of the subjects had mixed feelings of guilt, relief, confusion and satisfaction. This may be due to the abortion experience serving as both a coping strategy in response to an unwanted pregnancy and a stressor (Speckhard & Rue, 1992).

However, most women do react with mild feelings of depression. (Hafez, 1984; Kenyon, 1986; Pajnter, 1968). McGraw (1989) stated that up to 50% of women undergoing abortion will experience short term depression and guilt. Turell, et. al. (1990) reports that negative feelings of depression and anxiety were lower after the procedure, and much higher prior to the procedure. Lemrau (1988) and Adler (1975) divided the normal negative emotional reactions following an abortion, as internally based: regret, anxiety, depression, doubt and anger, and socially based: shame, guilt and fear of

disapproval.

Speckhard & Rue (1992) refer to the term post abortion distress (PAD) in that the post abortion response is perceived as an adjustment disorder when normal functioning has decreased and is seen as a direct result of the abortions. (Speckhard & Rue, 1992). Symptomatology is described as a general discomfort resulting from three possible areas regarding the abortion experience: a) physical complaints and emotional stress over the pregnancy and abortion; b) perception of loss as a result of the abortion; c) role conflict resulting from the perceived conflict surrounding the abortion decision.

Post Abortion Syndrome (PAS)

Many researchers investigating post abortion response look for prescribed severe psychiatric sequelae, rather than symptoms of self reported distress. This is possibly due to the fact that historically, prior to the 1973 Supreme Court decision, women needed a psychiatric reason in order to undergo what was then defined as a therapeutic abortion (Stotland, 1985). The literature reports different findings with respect to psychiatric sequelae resulting from an abortion. As early as 1954 (Rosen) post abortion syndrome was described: complaints of opposing feelings such as guilt, relief, depression, feeling out of contact, especially with her feminine role and its relationship to motherhood. Lidz (1954) added to this syndrome the notion of an unconscious sense of guilt (cited in Simon, 1966 p.381). Hern (1984) further expanded this description and described several post-abortion mental health problems: prolonged depression, functional incapacity, denial of procedure, sexual dysfunction, or post-abortion psychosis. Freudian theorists felt that a "denial of a pregnancy would be unnatural thus resulting in severe trauma" (Turell, et

al., 1990, p. 49).

Post abortion syndrome, has been suggested by those against abortion as a possible DSM-III-R psychiatric diagnosis (Wilmoth, 1992). The prevalence of psychiatric symptomatology varies depending upon when the research was done, and exactly what symptoms are being described. Early research indicates a much higher incidence of severe depression at 25% (Rovinsky, 1972). Present day evidence demonstrates otherwise, a 2.4% occurrence of psychotic reactions, and a 1-2% occurrence of major depression (Kenyon, 1986 p. 188). McGraw (1989) reported a higher incidence of severe psychiatric disturbance of 5%. The consensus amongst researchers is that if the woman had psychiatric problems prior to the abortion then her psychological symptoms post procedurally, tend to be greater (Adler, 1975; Dagg, 1991; Jacobsson, , et al., 1976; Kenyon, 1986; McGraw, 1989). Mcgraw (1989) and Turell, et al, (1990) found that women who are very passive and young were at greater risk for psychological reactions. Kenyon felt that those women who tended to have obsessional traits, high moral and religious standards and strong maternal feelings were at greater risk for severe psychopathology (1986, p. 190). Many of these symptoms can be explained by the physiological hormonal imbalance that is the result of the pregnancy, confounded by the subsequent sudden hormonal change due to the termination. It may take several days before a woman's hormonal level is stabilized (Kenyon, 1986).

Presently, post abortion syndrome research continues to investigate more severe responses following an abortion, with work being done in the area of post traumatic stress disorder. Speckhard and Rue, (1992) suggest that a very severe stress response to

abortion may cause post traumatic stress disorder. This is primarily due to the fact that post abortion syndrome is not recognized as a disorder within the psychiatric community, and this is a way of operationalizing it (Wilmoth, 1992). Symptoms include the experience of a perceived traumatic abortion, recurring negative events of the abortion experience in the form of flashbacks, nightmares, grief and anniversary reactions, avoidance or denial of the recollection of the abortion and symptoms of guilt not present prior to the abortion (Speckhard & Rue, 1992).

Context of Pregnancy; the Woman's Perception of Pregnancy/Man's Input and Their Effect on Post Abortion Response

What has been ignored in the research which may impact upon the woman's emotional response is the social and emotional context surrounding the pregnancy. A woman's perception and desire for the pregnancy, will contribute to the post abortion response according to Peppers, (1987). In addition, he believed that many women who delay abortion are often ambivalent about the pregnancy which created a greater grief response. He further proposes that the grief reaction following the abortion will be proportionate to the length of the pregnancy. Turell, et al., (1990) reports that women undergoing second trimester abortions have a more severe reaction, especially if quickening has been reported by the woman. The fetal movement is more suggestive of the reality of fetal viability. Major, et.al. (1985) and Adler (1992) state that women who felt their pregnancy was meaningful and wanted, coped poorly immediately after their abortion procedure, more so than those women who did not describe their pregnancy as meaningful. While women who intended to become pregnant, and then decided upon the

abortion were more depressed three weeks after their abortion. She suggests that these women valued the pregnancy more and felt it to be more meaningful than those who did not intentionally become pregnant. This conclusion is further supported by researchers who found that women who aborted because of fetal anomalies, had a more difficult emotional reaction, since they fully intended to have the child and wanted the child, thus implying that their pregnancies were meaningful (Dagg, 1991; Kenyon, 1986).

Little is understood regarding the man's input or the dynamics of the relationship with the conceptor, and its affect on women's post abortion reaction. Turell, et al., (1990) and Dagg (1991) found that women who maintained a strong relationship with their partners were more likely to experience regret over the abortion one year after the procedure. Contrary to this, McGraw (1989) felt that a woman would experience more problems if her relationship with her partner were unstable, or if she lacked any social support in general. A common post-abortion phenomenon is ambivalence towards the relationship which produced the pregnancy, often resulting in termination of the relationship (Bracken, et al. 1972; Francke, 1978). Simon & Senturia (1966) and Stone-Joy (1985) found that 40% of the 70 women in their study reported mixed emotions or dislike for the conceptor, after their abortion. Prior to the procedure, they believed that they loved the conceptor. Of this 40%, 18% soon ended their relationship. Stone-Joy (1985) found that women who felt guilty about their abortion, felt that their relationships would have continued had they maintained the pregnancy. Bolognese and Carlson (1977) reported that these women were actually grieving about the relationship ending and not the abortion. Fisher (1986) mentioned that many repeat aborters see their own fathers as

magical. In some cases this dynamic serves as a psychodynamic explanation as to why sexual relationships tend to dissipate after an abortion. The partner is initially associated with the magical father. Once the woman feels ambivalent and disappointed in the partner (due to the abortion), he then loses the role of the magical father abortion.

In addition to the quality of the relationship, how the conceptor views the impending abortion, and his capacity to support his partner will impact upon the woman's emotional response to the procedure. Major, et al., (1990) found that women adjusted better if they simply perceived partner support as opposed to those who told their partners about the procedure and he remained unsupportive. Similarly, Dagg (1991) however, found women who had unsupportive partners, had a worse adjustment than those women who chose not to tell anyone about the procedure. Stone-Joy (1985) reported a pathological grief response amongst women who were unable to discuss their abortion with family or friends. Kenyon (1986) felt women who did not involve their partners in the decision experienced a more severe reaction. In addition, there is evidence to indicate that the more conflict a woman has with the conceptor surrounding the abortion, the more angry and depressed the woman is after the procedure (Turell, et al., 1990).

Grief and Mourning

Generally when we grieve, we make an effort to explain events causally because it provides meaning and a context as to how and why a loss may have occurred. Grieving is a normal response to any loss (Berson, 1988). Experts separate grief and mourning as distinct stages of the bereavement process, which is the coping with a loss, (Berson, 1988; Goada & Ruark, 1984). Grief refers to the sudden acute state, that is composed of

somatic symptoms, preoccupation with the deceased, guilt, hostility, and possible erratic behavior. This acute state, is very uncomfortable. Often, many people will make an effort to avoid the grief state in order to alleviate the discomfort. Mourning occurs later, and is the more chronic stage of the grieving process. The mourning stage is the initial step of the healing process which serves as a way of closure and the subjects's return to normal functioning. Mourning is divided into three phases. The first is the protest phase: where the person clings to images of the deceased person and will often become angry at those who suggest that the person let go, which eventually produces discord in relationships. The second phase is despair, which is the emotional response when one finally acknowledges the loss of the deceased person: leaving the person feeling depressed and anxious. The final stage is detachment, when the person reorients their life toward activities of living.

Grief and Mourning in Voluntary Abortion

Little investigation has been done with regard to the emotional response of loss and mourning, regarding a voluntary abortion. The bereavement process is applicable as a normal psychological response to abortion, especially if the women are ambivalent or desirous of the pregnancy. Regardless of it's voluntary status abortion can still be viewed as a loss followed by a grief reaction as presented by some researchers in the literature (Peppers, 1987; Speckhard & Rue, 1992; Stone-Joy, 1985). Loss can be either sudden or anticipated (Lamb, 1988). Voluntary abortion may be experienced by some women as an anticipated loss. Maternal grief is recognized in instances of miscarriage, stillbirth and spontaneous abortion (Peppers, 1987). In involuntary pregnancy loss, there is much

danger when the mother blames herself for the situation (Dunn, et al.,1991). Maternal infant bonding begins in the prenatal period (Peppers, 1987). One would suspect that if the woman is in any way or to any degree wanting (reflected in the level of ambivalence) of the pregnancy, she may in fact experience a loss. Loss and grief are experienced because the bonding is cut short. Maternal grief is defined as "a mother's highly variable emotional, psychological, physical and social response to the involuntary loss of her fetus or infant (Peppers, 1987 p. 1)." Many women who do terminate a pregnancy do feel some sense of loss. If an abortion was defined as therapeutic in order to preserve the woman's psychological and/or physical well being, maternal grief may be perceived as prohibited because due to the fact that the abortion is viewed as voluntary. Peppers (1987) notes that we acknowledge maternal-infant bonding and the resulting maternal grief in the cases of miscarriage, stillbirth and sudden infant death syndrome. We do not acknowledge maternal bonding and grief with respect to a voluntary abortion. Yet, Peppers (1987) found that women grieved both before and after their abortions. In his study he found that the grief related to abortion was very similar to grief as a result of involuntary loss. The women in his study showed a greater amount of grief right before their abortions. The author then concluded that the women started grieving when they made the decision to abort, not at the actual abortion. He concludes from this that the women who were grieving perceived their pregnancies and recognized it as a fetus and a potential child.

Indeed, many women feel that they could have done something to prevent an abortion, thus blaming themselves in some way. Women who have had an abortion may

feel a need to blame either themselves, their partners, or society. Mueller, et al., (1989) found that women who blamed their pregnancy entirely on external forces(such as their partner), and had little self competence had the worst post abortion adjustment. Campbell, et al., (1988) notes that many older women had a greater desire to have a child, after the abortion experience. Stone-Joy (1985) reported that many women believed that their earlier abortions were the cause of their current fertility problems.

Goada and Ruark (1984) suggest that guilt can be the signs of a pathological grief response. This is when the person feels somehow responsible for the deceased person's death. When it comes to abortion, many women find the guilt feelings inevitable. People often try to avoid the discomfort of the grief stage by not talking about the deceased, which will inhibit the bereavement process (Berson, 1988). Indeed many women do not discuss their abortions or how they felt after them with anyone. Corsaro and Korzeniowsky (1983) suggest that if women continue to feel depressed after an abortion they should mourn the loss by using a self-selected ritual. They point out that Japan has a funeral service for the deceased fetus. McCall & Wilson (1987) used a communion ritual in their study of mourning after an abortion. They found that most of their patients' psychological and psychosomatic symptoms halted after the ritual. Interestingly, there is a societal understanding in many cultures that a mourning ritual is available for those who have experienced a spontaneous abortion, but this has not been instituted for those who have undergone voluntary or therapeutic abortions.

Researchers have done little to isolate the repeaters and multiple aborters with regard to mourning and post abortion response. McGraw (1989) believed that psychiatric

sequelae is higher amongst repeaters. Yet, many single aborters stated that they would have a second procedure if they ever had an unwanted pregnancy (Burnell & Norfleet, 1987). Mueller, et al., (1989) found no difference between single aborters and repeaters with respect to their levels of self blame. Heinrich and Bobrowsky (1984) concluded that; "The presumed trauma of having an abortion is not a strong deterrent to having another (p. 263)." Campbell (1990) found no significant differences between single, repeaters, and multiple aborters in their self reported emotional response to the procedure. Freeman, et al., (1980) compared repeaters to single aborters and found repeaters presented with much more anxiety, somatization, hostility, and sleep disturbances following their abortions. The authors concluded that repeat aborters had a slower resolution of feelings over the unwanted pregnancy. Similarly, Hafez (1984) concluded that since most women tend to repeat abortions in the first year, the repetition was due to a delayed yet undescribed emotional reaction. As could be expected, he also found that women who were more disturbed prior to the procedure would have greater psychological problems after the procedure.

One might expect that women who have undergone multiple procedures are in little danger of experiencing either post abortion reaction or post abortion syndrome. It could be presumed that they have adjusted to the situation and experience, thus eliminating any apprehensions thereby decreasing anticipatory stress. On the contrary, women who are defined as multiple aborters are presented in the literature and in clinical practice, as having greater pathological and negative post abortion responses. It is believed the multiple aborter is trying to achieve a mastery over her abortion behavior in

order to alleviate the guilt. She is described as more concerned with the medical aspects of the procedure, rather than the moral aspects. ("Repeat Abortion," 1989). Stotland (1985) states that psychiatric consultations are sometimes necessary for those women undergoing an abortion, due to unresolved feelings from a prior abortion. Deutsch (1945) stated; "women with a need to conceive will react to abortion with a new pregnancy or severe neuroticism" (as cited in Simon, 1966, p. 379), albeit the definition of severe neuroticism is unclear.

McGraw (1989) presents an extreme case of pathology study in a single case analysis. The patient is described as a woman diagnosed with obsessive compulsive disorder who had 3 abortions and four marriages. The first two abortions were performed in her mid teens, and the third when she was in her early twenties. The earlier procedures were at her parents' insistence, while the third was on her own. The woman had obsessive thoughts believing that she had gynecological cancer and sexually transmitted diseases, as punishment for her prior abortions. Her compulsive acts were centered around gynecological exams and home pregnancy tests. She felt so guilty about the prior procedures that she thought God would kill her in childbirth, and so ambivalent about having a child that she became psychologically compromised and developed pseudocyesis (hysterical pregnancy).

Acute grief states are often avoided by mourners because of the emotional pain provoked (Berson, 1988; Goada & Ruark, 1984). Clearly, the avoidance of this grief would in fact delay the whole bereavement process. The possibility of a delayed emotional response occurring years later is suggested in terms of the abortion experience

(McGraw, 1989; Speckhard & Rue, 1992; Stone-Joy, 1985). Kenyon (1986) suggests that a reactive depression may manifest itself during the "birthday" of the child, or the "anniversary" date of the abortion. Stone-Joy (1985) felt many women who reported symptoms of depression are actually experiencing a delayed and unresolved grief reaction. These women tend to come in for psychological treatment around the time the baby would have been born.

A delayed grief response can be implicated as a possible variable for those women who have undergone multiple abortions. A woman with a more severe post abortion reaction i.e. post abortion syndrome, may in fact be more likely to delay that mourning. The mourning would then manifest itself in other ways, such as repetitive thoughts. If the post abortion reaction was perceived as traumatic, the recall of the abortion, and the events surrounding it would be an intrusive and uncomfortable thought for the women. Not only are thoughts of the event repetitive, but so are ". . . emotional states, symbolic interactions, memories, cognitive strategies and patterns of behavioral re-enactments varying in intensity style and duration, and beyond the volition of the individual (Horowitz & Becker, 1972, p. 259-260)." One style of these behavioral re-enactments would be the cognitive intrusive thoughts and mental re-experiencing of the abortions. This is similar to the description of symptoms described in post abortion syndrome (Speckhard & Rue, 1992).

The delayed grief response has also been implicated as a psychological cause of multiple abortions. These behavioral re-enactments could include future pregnancies (Fisher, 1986; Speckhard & Rue, 1992). That is, the initial denied grief from one

procedure lingers unconsciously, and the way to alleviate the guilt may be through another pregnancy. Once cognizant of the pregnancy, she is then faced with the socio-economic and emotional realities of her situation, which may result in another abortion. This new pregnancy is the "replacement pregnancy" ("Repeat Abortions," 1989) which results from the combination of guilt, self blame, atonement and difficulty in mourning for the prior pregnancies. These emotions have all been found to contribute to the dynamics of the subsequent or current pregnancies, thereby producing anxiety or depression in that woman. Kenyon (1986) suggests that "this anxiety or depression from the abortion was suppressed by these women and is reactivated by their new pregnancy" (p. 189). Steinhoff, et al. (1979) found that many of his repeaters had made strong emotional associations between births subsequent to their prior abortions. Many women felt an increased desire for a child after an abortion, although multiple aborters were more likely to drink or smoke during subsequent pregnancies ("Repeat Abortions," 1989). This combination of positive and negative prenatal care serves as a further indication of her ambivalence, or guilt from a prior abortion, and the current pregnancy. This fits with the aforementioned notion of post traumatic stress disorder, and it's relationship to post abortion syndrome.

The above literature review explains how research findings regarding women's response to abortion has varied through the years in terms of cause, symptoms and severity. It is difficult to isolate a single definition of post abortion response, or the variables that may cause it. Even less has been done to investigate the psychological sequelae that may result from or cause several procedures. What is clear, is that the psychological sequelae, the notion of bereavement and grief in abortion continues to incite

debate, due to the inconclusive findings, and current political climate surrounding abortion.

The Link Between Decision Making and Post Abortion Response

The link between pregnancy resolution, and the response to the resolution appears evident: "A woman's decision making process appears to be the variable that best explains such differences in emotional response" (Turell, et. al., 1990, p. 50). Mueller and Major (1989) found that causal attributions toward the pregnancy helped to determine the coping response to an abortion.

Several researchers have shown that if a woman is dissatisfied, ambivalent or had difficulty making her decision to undergo an abortion, the emotional response following the abortion is more severe (Adler, et al, 1992; Adler, et al., 1990; Adler, 1992; Osofsky & Osofsky, 1972; Stone-Joy, 1985). Turell, et al., (1990) reports that those women who were uncertain in their decision experienced a great deal of regret, anxiety depression, doubt and anger. Women who made the decision independently, and took the responsibility of their action were reported to suffer less trauma. Overall, women who own their decision to abort, and utilize effective decision making skills such as talking about the abortion decision, and seeking supports experienced less distress after the procedure than those who did not.

Women at greatest risk for psychological distress after an abortion were those women who were extremely ambivalent about the procedure and women who experienced high anxiety upon first hearing the pregnancy diagnosis (Kenyon, 1986; Turell, et al., 1990). Peppers (1987) felt the ambivalence in the decision making could affect the

resolution and mourning of the abortion. According to Adler (1992) ambivalence can be a mismatch between the different aspects of the intention to become pregnant, that is her desire to become pregnant and her planning to become pregnant. For example a woman may want to become pregnant but not do anything in order to increase her chances of conceiving. McGraw (1989) found that women who based their decision on what the parent's or the partner wanted were at greater risk for a post abortion reaction. Stone-Joy (1985) felt that women who made their decision in haste, secrecy, isolation, and had the desire to stop thinking about the event as quickly as possible were more likely to experience a greater degree of loss after the procedure. Adler (1975) reports that women who had difficulty deciding to abort reported stronger internally based emotions (regret, anxiety, depression, doubt, and fear) following the procedure. Turell, et al., (1990), found that the degree of satisfaction after an abortion is inversely correlated with the amount of ambivalence prior to the procedure. In addition, these authors suggest that younger women suffer more severe emotional trauma subsequent to a procedure, due to their underdeveloped decision making skills. It is felt that younger women lack confidence in their decision and thus unable to trust their final decision.

Goada and Ruark (1984) discuss the notion of anticipatory grief in terminally ill patients. Once the patient, family, and medical staff are aware of the finality of the patient, a letting go process has begun on the unconscious level. These authors believe that the anticipatory nature allows for a more successful coping strategy. The author of this paper suggests that this may be occurring for women who have decided to terminate their pregnancies. That is, once they have made the decision to abort, women will begin

a process of letting go. The question arises as to what happens to the anticipatory grief for women who have undergone multiple abortions? One could speculate that if a woman is uncertain about her decision to abort, she is less likely to experience anticipatory grief, which would then result in unfinished mourning, causing cognitive and behavioral re-enactments of the pregnancies.

In sum, the above literature review reports an immense morass of information. Many of the studies cited provide conflicting information, not allowing for consistent deductions regarding the abortion experience. There are number of explanations that address the conflicting results. Variable definition is a major component of any research design. Most of the research in abortion has suffered from problems with variable definition in that there is not a consensus amongst researchers. For example, many studies have combined different abortion experiences: saline, medical, illegal, and illegal procedures into one category for investigation (Aguirre, 1980). Clearly these are distinct experiences with a multitude of factors unique to each one. Some studies combined single, repeat and multiple aborters into one category (Heinrich & Brobosky, 1984), leaving the definition of multiple abortion poorly defined and poorly investigated. Some of the research already cited did not make a distinction between contraceptive failure (an unreliable method) and contraceptor failure (the user is unreliable in the application of the method). Other studies investigate one cultural group (Berger, et al., 1984; Skjeldestad & Bakketeig, 1986; Tsoi, et al., 1987) which limits the ability of the studies to extend their conclusions to all women. Most research on abortion was done in the late 70's and 80's, due to the Roe v. Wade decision, which made the issue open to public debate.

Much of the research on abortion is reflective of the political debate (Wilmoth, 1992). That is, when attitudes were more liberal in the seventies, research findings tended to report positive results, as attitudes became more conservative, findings became more negative.

Another issue which may cause inconsistencies in the research is the timing of when a study is given, due to subject variation over time in the areas of memory, recall, and how they may change in their definitions of different issues (Campbell, et al., 1988; Christensen-Szalanski, 1984; Rosental & Rosnow, 1991; Tietze & Bongaarts, 1982; Turrell, 1990;). In some of the studies cited, subjects were given questionnaires either before, during or after their abortions. Clearly, the subject may be at different emotional or developmental states at the time of the survey application, which would influence the quality of the response (Blackburne-Stover, 1982).

Goals, Purpose and Rationale of the Study

The objective of this study is to investigate the phenomenon of multiple first trimester elective abortions. The literature on single and repeat aborters proves inconclusive, while little has been done in terms of examining the phenomena of multiple abortions. This is an exploratory study, with the intention of generating theory by the use of comparative analysis. Efforts will be made to clearly define the parameters of multiple abortions, and to describe specific variables that lead women to have several procedures. The literature as well as this researcher's personal experience of working with women in many aspects of reproductive health, indicate that the issue of multiple abortion is complex. As indicated, the phenomenon of multiple abortion as a research issue is

relatively new and poorly defined as a distinct entity in the literature. It is clear that certain issues must be elucidated prior to an attempt to discuss the psychological processes that may contribute to multiple abortions. The above literature review demonstrates is that it is not a simple matter of women using abortion as a birth control technique, nor is it so straightforward to define the issue of multiple abortion as indicative of psychopathology.

The goal of this investigation is threefold. The first goal is to develop a more exact definition of the phenomenon of multiple abortion. Efforts will be made to look at the time sequence of multiple abortions to see if it plays a role in yielding a more precise definition. In current literature the time sequence is unexplained and has gone without investigation when discussing multiple abortions, which was previously defined as three voluntary first trimester abortions. The question arises as to a possible difference between a woman who has had at least three consecutive procedures and the woman who has had procedures spaced out between full term pregnancies and other reproductive events. For example, is a woman who has had 5 abortions over a span of 20 years somehow distinct from a woman who has had 5 abortions in 3 years? According to Tietze (1977), within a ten year period a woman has a 20-50% probability of having to undergo a second abortion, even if she is taking the most effective birth control; oral contraceptives. Clearly, the possibility of having a second procedure may be due to more than mere chance. What is the probability of having three consecutive procedures?

The second goal is to investigate the psychological context of the conception and pregnancy, the decision making process and the psychological and behavioral aftermath

of multiple abortions. The aim is to see if there is something distinct in these two psychological mechanisms that may occur among those women who have undergone multiple procedures. If so, this psychological process may be predictive of multiple abortion. Presently, it is unclear whether or not multiple abortions are a particular event that may happen to any woman due to extraneous circumstances, pure chance, or whether multiple abortions happen to a woman with a particular cognitive style. The three phases of the abortion experience occurs for all aborters, there may be something awry in one phase which repeatedly lead a woman to the last resort and undergo multiple abortions.

The previously stated notion of "erratic contraceptive use and a history of unsettled relationships" amongst multiple aborters (Brewer, 1977) suggest that there is something different in the reproductive decision making processes of these women. One could speculate that women who have undergone multiple procedures are utilizing different decision making skills, due to feeling more ambivalent towards the pregnancy. Feelings of confusion, and possibly shame, and uncertainty of personal ability, might lead these women to limit the number of people to discuss the impending abortion with, thereby eliminating some of their necessary support. She then limits the number of people the women will discuss the abortion decision with. The women then focus on one person's (the conceptor) to help make her decision. If his support is incongruent with her feelings toward the pregnancy, the abortion experience then begins to go askew.

The post abortion response will be investigated in order to determine how the multiple aborter responds to several procedures; to see if she is significantly more likely to suffer from a greater degree of mourning or grief, post abortion syndrome or to suffer

from a more severe post abortion reaction. When discussing the effects of multiple abortions, little is available in the social science literature, most information comes from the medical science literature. Although abortion is a safe surgical procedure, multiple procedures increase the possibility of miscarriage, excessive dilation and premature births, and low birth weight infants in future full term pregnancies (Jacobsson, et al., 1976; Kenyon, 1986; Williams, et al., 1989). In addition there is greater exposure to hemorrhage, perforation of the uterus and infection, and scarring of the uterus, due to the increased number of procedures.

This study explores whether multiple aborters go through a different decision making process by allowing others to make the decision for them via their influence, because they are so ambivalent about the decision to abort due to ambivalent feelings towards the pregnancy. It is possible that they are relying on their partners to convince them in order to solidify their decision, which may conflict with their own internal ambivalence toward the pregnancy. If so, this could compound the problems of the women's general coping skills, thus producing greater psychological sequelae following the abortion. Is the woman undergoing a bereavement process that is not beneficial to this situation; thereby experiencing something other than an anticipatory grief, since the decision making process did not leave the woman with a comfortable resolution? Given the higher frequency of psychiatric consultations and unstable relationships, it is possible that these women have greater difficulty committing to their pregnancy decisions which then results in a more severe post abortion reaction. This difficult cognitive process then exposes her to these behavioral repetitions of the pregnancy, leading to future abortions.

This study suggests that the interaction between the phases of the abortion experience: the pregnancy or conception context, the decision making process and the post abortion reaction, may cause women to have multiple procedures. If women who are defined as multiple aborters are more ambivalent towards their pregnancy, it may result in an excessive reliance on the conceptor's opinion to help solidify her already ambivalent decision to have an abortion. A conflict then exists between her ambivalent feelings towards the pregnancy and her own decision, and the conceptor's support of the abortion. This conflict then results in a more severe subsequent post abortion reaction, due to a decreased satisfaction with their final decision.

This study is unique in that it will the entire abortion experience from the point of awareness of the pregnancy to the post abortion response. It is very difficult to separate the post abortion reaction from the context of the entire pregnancy, this would include the conditions of the conception to the abortion (Adler, 1992). Prior research has often isolated variables into areas that are often categorized as pre or post procedure, often neglecting the temporal relationship and cognitive processes that occurs between the knowledge of conception and the post abortion reaction. It is clear that the perceived social and emotional contexts of a pregnancy will affect a woman's decision to abort, and the psychological reaction to that abortion. Miller (1980), suggests that there are a series of continuous psychological states that extend from the actual act of intercourse to childbirth. Abortion is one of the alternatives to that childbirth. Proposed in this study, is a contextual model that looks at the circumstances of the conception and pregnancy, which influences the decision making process, which then results in a specific post

abortion reaction. It is this model which then defines the potential for multiple abortion.

As a third goal, this study has several implications for mental health care providers and those in women's health care services. Tietze and Bongaarts (1982) concluded that repeat abortions are an indication of a failure amongst health professionals to educate. In clearly defining the multiple aborter and the phenomenon of multiple abortion, there would be a decrease in personal judgement on the part of clinicians, and fewer implications for diagnosing other forms of psychopathology. Once multiple abortion is clearly defined, treatment guidelines could be provided which would address the multiple abortions itself and not the misperceived underlying psychopathology of the aborter. Clinicians and professionals who provide pre and post abortion counseling would will address the conception and pregnancy context, the decision making processes and post abortion reaction with multiple aborters who have gone unnoticed in the abortion system. Many women who have undergone several voluntary abortions tend to feel that hospital and counseling staff treat them negatively (Jacobsson, et al., 1976). By understanding and addressing the entire abortion experience and it's psychological components within each phase professionals could provide an alternative in the counseling process. Thus eliminating the tendency to undergo several procedures, while still allowing women to maintain reproductive control.

Statement of Hypotheses

The hypotheses of this dissertation are as follows:

1. When compared to the single or repeat aborter, the multiple aborter is likely to feel more ambivalent about her

pregnancy/pregnancies. This is measured by the Intendedness and Wantedness Scale, the Blame Scale and the Maternal Motivation Questionnaire.

2. Multiple aborters are more likely to feel ambivalent about their beliefs about abortion. This will be measured by the Abortion Decision Questionnaire and the Reasoning about Abortion Questionnaire.
3. Multiple aborters are more likely than the two other groups to be influenced by their partners in their decision making. They are more likely to rely on his input. This is measured by the Interpersonal Influence Inventory Scale.
4. When compared to the single and repeater, the multiple aborter is more likely to perceive the partner/conceptor as the most supportive regarding the entire abortion experience, in comparison to other significant people with whom she may have discussed the abortion. This will be measured by the Social Support Subscale.
5. Multiple aborters are more likely than single aborters and repeaters to undergo more severe post abortion responses including post abortion reactions (Emotional Questionnaire and Perceived Self-Efficacy Scale); greater mourning and grief response (Post Procedure Questionnaire); or post

abortion syndrome (Impact of Event Scale).

6. Women who have undergone at least three consecutive voluntary abortions are more likely than women who have not had three consecutive procedures, to feel ambivalent towards the pregnancy and abortion issue. They are more likely to report ambivalence on their decision to abort. They are more likely to incorporate the conceptor's opinion of the pregnancy resolution, and see their partners as more supportive of the abortion experience. Also, they are more likely to experience severe post abortion responses.

METHODOLOGY

Subjects

Subjects consisted of a non-clinical sample of women from the New York City area. The women were recruited from different college campuses. The sample included single and married women. Women who had abortions prior to the 1973 decision were excluded from the study, since they are less likely to have undergone a standardized medical abortion or contraceptive counseling. These women were also more likely to have had an illegal abortion, and hence the circumstances surrounding the abortions were much different. Only those women who have undergone first trimester voluntary abortions were included since second trimester abortions are considered a more serious procedure, both psychologically and physically (Wilmoth, 1992). Women who had both general and local anesthesia for their abortion procedure were included.

It is highly likely that some subjects may have had one or several of their procedures during adolescence. There is empirical evidence that argues that adolescents are capable of making the decision to abort (Ambuel & Rappaport, 1992; Interdivisional Committee on Adolescent Abortion, 1987; Lewis, 1987, 1980). With regard to post abortion responses, the literature indicates that while adolescents differ in their post abortion responses (more likely to seek parental support post procedurally) they do not have significantly greater post abortion reactions, grief reactions or post abortion syndrome (Interdivisional Committee on Adolescent Abortion, 1987). Hence, the age at which a woman had her abortion will not be a variable of concern.

Subjects were divided into three groups for comparison. Group one consisted of

women who were single aborters (one abortion). Group two was comprised of repeaters; women who had two procedures. The third group consisted of multiple aborters: those women who have had three or more abortions. In order to do the within group analysis to investigate hypothesis 6, the multiple aborter group was further divided: consecutives (at least three successive first trimester voluntary abortions) and nonconsecutives (intermittent multiple abortions dispersed between other reproductive events).

Instruments/Measures

The survey packet consisted of several questionnaires and subscales selected to measure the specific domains of the entire pregnancy experience prior to and including the actual abortions. This is in line with the goal of this study to encompass the entire pregnancy experience for both the single, repeater and multiple aborter. Women who underwent several abortions are asked to respond collectively with respect to all of their abortions, thus summarizing the abortions into one composite experience. This is based on the assumption that subjects may not be able to separate the specific procedures, thereby resulting in one cluster memory. Also women are more likely to recall the most extreme positive and adverse circumstances. A copy of the survey and the interview questions are located in appendix A.

Abortion Demographic Questionnaire. A questionnaire conceived by the author of this study, consisting of 23 fill-in or multiple choice questions designed to ascertain current pertinent descriptive information regarding the subject, her abortions, and overall reproductive history. In addition, a time line is presented which allows the respondent to put all her reproductive events into temporal perspective. The Abortion Demographic

Questionnaire was originally developed in 1988, and consisted of demographic questions that were only descriptive of the women. Face validity was attained after speaking to many physicians and social science specialists in the area of women's reproductive issues. The Abortion Demographic Questionnaire was then amended to include semi-structured questions which provide detailed information about a subject's parity. Investigated areas discussed are current methods of birth control, history of reproductive events, information about the conceptor and descriptive information regarding the abortions. Women are asked about each procedure; where the procedures were performed, who came to the procedure with the subject, possible complications and subsequent birth control. For the purpose of this study, the Abortion Demographic Questionnaire will be used to define further the parameters of the definition of multiple abortion, by looking at the aforementioned variables. Efforts will be made to investigate the time factor variable, by investigating those women who have had three consecutive abortion procedures, and those women who have had intermittent multiple abortion procedures between other possible pregnancy resolutions and other reproductive events.

Conception and Pregnancy Context

This domain is defined as the time period in which women are required to think about the fact that they are pregnant, but have yet to commit to a specific pregnancy resolution. Specifically, it refers to the period prior to the perceived moment of conception to the onset of the decision making process to have the abortion(s).

Pre-Procedure Questionnaire: Blame Subscale. A Likert Scale which estimates the types of attributions that women use with respect to how they became pregnant

(Major, 1985; Mueller & Major, 1989). There are five possible blame categories; other person blame, situational blame, chance blame (bad luck), self-behavior blame (considered more controllable) or self-character blame (less control over these due to characterological traits). Questions are asked directly for each category. Subjects are asked to rate their response on a scale from 1 (not at all) to 7 (very much). Reliability among the blame categories has been determined by similar correlation patterns found in current and prior research conducted by the author. Self-behavior and self-character blame are positively correlated ($r=.15$, $p<.01$). A negative correlation exists between the chance ($r=-.11$, $p<.05$) and self-behavior blame. A negative correlation also exists between self-behavior blame and other person blame ($r=-.16$, $p.<.01$). Positive correlations were also determined between chance blame and situation blame ($r=.12$, $p.< .05$), and between chance blame and other person blame ($r=.18$, $p.<.01$). In this study, the Blame Subscale will assess how a subject perceives the pregnancy specifically what she attributes as the underlying reason of how she got pregnant. This will assist in assessing the emotional context of the conception and pregnancy.

The Intendedness Scale. A structured rating scale designed to measure the behavioral events prior to pregnancy that may or may not lead to conception (Miller, 1980). The scale is suggestive of those psychological states and behaviors that occur prior to conception that reflect the individual's orientation toward the possibility or planning of an event's occurrence. Subjects are asked to respond to 12 multiple choice or yes/no questions. Subjects' responses are then given an assigned rating of intendedness. Questions consist of behavioral acts and feeling states that correspond to either the

achievement or the prevention of conception. There are seven possible ratings: 1) contraception is stopped or avoided with the conscious intention of conceiving, i.e. conceptions are fully intended; 2) contraception is stopped or avoided with an ambivalent intention to conceive, i.e. conceptions are ambivalently intended; 3) contraception is stopped or avoided under conditions where there is a clear difference of intention between the subject and her partner, i.e. conception is ambivalently intended; 4a) contraception is not used, a woman is aware that her sexual and contraceptive behavior involves a significant risk of conception, but reports feeling that should she get pregnant a baby would be welcome, i.e. conception is subintended; 4b) contraception is not used, either the woman is aware that her behavior involves a significant risk, but would not welcome a baby or, she is not aware of the risk but would welcome a baby i.e. conception is subintended 5) is used irregularly, but with no conscious intention to conceive, i.e. conception is subintended; 6) contraception is used regularly and effectively, except during one brief point in time (one or several instances of sexual intercourse) as a result of situational factors but with no conscious intention to conceive, i.e. conceptions are non-intended; 7) contraception is used regularly and effectively, i.e. conception is non-intended, pregnancy results from an apparent contraceptive method failure.

The Intendedness Scale has a high interrater reliability amongst four trained raters, who judged the level of intendedness of 20 possible vignettes suggestive of different levels of intendedness. There was only two reported disagreements amongst the raters. A high rate of reliability between husband and wives was found by the original author of this scale. The responses to the vignettes were then reconstructed as responses to multiple

choice questions that reflect behaviors that either avoid or promote conception. In this study directions and questions have been adjusted to reflect the retrospective format, the consideration of only those pregnancies which resulted in a first trimester therapeutic abortion and the possibility of multiple abortions. The Intendedness Scale is used to determine the aspect of ambivalence in terms of the intention (planning to become pregnant) of those pregnancies that resulted in first trimester abortions.

The Wantedness Scale. Miller (1980), developed this rating scale that evaluates the psychological states occurring after conception, assessing how the woman feels about and responds to an already determined pregnancy or child. It is designed to take into consideration both the subject's feelings and her perceptions of her partner's feelings, since many women will consider their partner's feelings in order to determine their own feelings of wantedness toward the pregnancy (Miller, 1980). Subjects respond to three structured questions devised to draw upon a subjects feelings of either acceptance or rejection of the already determined pregnancy. The responses are then ascribed a level of wantedness, which is predetermined by the author of the scale (Miller, 1980). The five levels of the dimension of wantedness of the pregnancy or child is: 1) actively desired with no important reason for not wanting it; 2) actively desired in spite of one or more important situation reasons for not wanting it; 3) only passively accepted as a result of one or more important situational reasons, and the subject although not rejecting it, would not choose to have the conception, pregnancy, or child if she could go back in time (ambivalence); 4) only passively accepted with serious consideration given by the subject to ridding herself of it by abortion, adoption, or some form of relinquishment

(ambivalence); and 5) actively unwanted and rejected through such actions as abortion, adoption, abandonment, relinquishment, or hostile child care. A high level of interrater reliability was established by four judges rating 20 vignettes which described different levels of wantedness of the pregnancy. The vignettes were reorganized into multiple choice questions. Each answer to the multiple choice questions are assigned a level of wantedness. In this study directions and questions have been adjusted to reflect the retrospective format, the consideration of only those pregnancies which resulted in a first trimester therapeutic abortion and the possibility of multiple abortions. For this dissertation the Wantedness Scale is used as another measure to assess the aspect of ambivalence towards the pregnancy.

Maternal Attitude Questionnaire (MAQ). An attitudinal questionnaire designed by Miller (1980) to measure the level of motivation for childbearing. The content of the questions reflect negative and positive opinions on various aspects of maternity and mothering. The MAQ has two parts; the desirable (28 questions) and undesirable aspects (21 questions) of being pregnant and a mother, or positive maternal motivation and negative maternal motivation, respectively. Subjects are given four possible responses to each statement, depending upon their level of desirability or undesirability: very, moderately, slightly, or not. Prior psychometric investigation yielded two primary criterion scales: a desired family scale which determines how large a family the woman may want. The pregnancy now scale is capable of discriminating between those women who are trying to conceive and women who feel that getting pregnant at the present time would be extremely undesirable for them. A positive maternal motivation score is based

on the mean of all the items from part one. A negative motivation score is similarly computed from all the items in part two. A net maternal motivation score is based on the difference between the scores. Reliability was assessed revealing a Cronbachs alpha for a positive motivation scale at .93, for the negative maternal motivation scale Cronbach's alpha was .91, and for the net score it was .94. Subjects were retested one month later, correlations were set at .87, .80, and .86 for the positive maternal motivation scale, the negative maternal motivation scale, and the net maternal motivation score, respectively.

Pregnancy Resolution

This section of the survey refers to the time period from the moment a woman begins to actively consider abortion as an option to the final confirmation that abortion is the solution to the unwanted pregnancy.

Abortion Decision Questionnaire (ADQII). This questionnaire is a result of a tabulation of the most frequent responses by 82 women who were either never-married or married and made a decision about having an abortion during the course of the three year Psychology of Reproduction Study (Miller, 1980). The Abortion Decision Questionnaire asks subjects to rate (ratings: very, moderately, slightly, not) how important each of the 12 reasons to abort and 11 reasons not to abort. In terms of this study, this questionnaire will assess the personal factors of the abortion decision making for the subject.

Reasoning About Abortion Questionnaire (RAQ). (Parsons, et al., 1990). This Likert scale consists of twenty questions, which measures the single dimension of reasoning about abortion. Possible responses extend from a "strongly disagree" to

"strongly agree." The questionnaire reveals two opposing positions behind a woman's reasoning. One opinion is traditional with the "right to life" position. The reasoning against abortion was based upon beliefs that abortion was murder, the fetus was a human being, and abortion is morally wrong. Women who continue an unwanted pregnancy based on these beliefs are referred to as "moral reasoners." The other noted position is typical of the "pro choice" position. Arguments supporting this position was that birth is the beginning of human life, the fetus is an extension of the mother, and therefore abortion is a woman's right. Women who hold this position are likely to have an abortion based on very personal and private reasons. Subjects who believe in this position are referred to as "personal reasoners." Ten of the questions refer to a moral focus on abortion e.g. "Abortion is the same as murder," and the remaining ten are indicative of an individual position e.g. "Abortion is a matter of personal choice. Subjects circle a response ranging from 1=strongly disagree, 3= mixed feelings, and 5=Strongly agree.

The split-half reliability correlation revealed high negative correlations between the scores of moral and personal reasoners (r= -.94 for the first testing, and r= -.93 for the second testing. Test-retest reliability reveal a correlation of .98. Correlations of both the moral reasoner and personal reasoners scores were measured across two separate assessments. Construct validity of the scale was established by follow up structured interviews with selected subjects who scored in the extreme ends of both poles. For the purpose of this study the Reasoning about Abortion Questionnaire will be a variable in the pregnancy resolution phase. It will measure the women's opinion of the abortion issue which affects her decision making. That is, women who do believe in abortion

rights are more likely to see it as an option in their resolution of an unwanted pregnancy.

Pre-Procedure Questionnaire: Social Support Subscale. (Major, et al., 1990; Mueller & Major, 1989). These are six questions that ask the subjects specifically about three sources of support during the decision making process, and after the actual procedure: friends, family and partners, and to rate the level of perceived support. Ratings extend from "doesn't support me at all" (1) to "totally supports me" (7). In addition subjects are offered a "not applicable"(0) response, for instances in which the subject has not informed the person of the abortion. In this study, the social support subscale will address the fourth hypothesis in order to determine the degree in which the subject perceives the partner's level of support, and how many others she involved in terms of seeking support.

Interpersonal Influence Inventory (IIS). A sixty item questionnaire consisting of different life decisions throughout the life span (Wilson, 1986). The different life decisions on the IIS are based on the adult development theories of Levinson. Thus questions consist of 9 critical life choices faced in early and middle adulthood: community involvement, family, friendship, goals, leisure, political involvement, religion, work, and residence (Levinson, 1978 as cited in Wilson, 1984). Subjects are asked to rate the level of influence they received from their partner on each of the decisions they made. Subjects can select from (1) no influence to (5) very much influence. Administration is approximately 15 minutes. Scoring consists of the summation of all the responses. Content validity of the actual life choices were determined by expert judges in the field, and judges similar to the intended population of adult women. Test-retest reliability using

a Pearson product moment correlation was computed for women and men at .837 and .890 respectively. Additionally, stability coefficients were calculated at .907 for women and .893 for men, by the author (Wilson, 1984). Internal consistency using Cronbach's alpha was computed for women at pilot and retest at .990 and .963 for women, for men it was .933 and .937 at both testings. There is a male and female version of this measure, for this present study only the female version will be used in determining the level of influence a partner has in a woman's decision making.

Post Abortion Response

This refers to the emotional responses subsequent to the abortion(s); post abortion reaction, mourning and grief response and post abortion syndrome.

Perceived Self-efficacy Scale (PSES). A measure originally designed by the authors in an attempt to assess self efficacy for coping with abortion (Major, et al., 1990; Mueller & Major, 1989; Major, 1985). The original measure consists of 10 items of post abortion coping behaviors arranged in ascending order of difficulty. Items were selected based on previous piloting by the same authors in order to measure self-efficacy. Self-efficacy is the perceived coping expectation in predicting adjustment following a stressful life event. (Major, et al., 1985). Originally, the authors administered this measure to women before they had the procedure in order to assess how women think they might respond to an abortion. Subjects were asked "to think about how you will feel after your abortion today," thereby asking subjects to ascertain how they might respond in terms of post abortion coping behavior. The ten items on the scale were positively and significantly interrcorrelated. Major, et al., (1990) reports correlations ranging for .10 to

.62. Internal consistency estimate of reliability was determined (.84) using Cronbach's alpha. The original Perceived Self-efficacy Scale was modified for the purpose of this study to reflect the retrospective format and the inclusion of multiple procedures. In addition the directions were changed to " think about how you felt after your abortion." Women were asked to respond to each behavior by selecting a number on a scale ranging from 0 (couldn't do it) to 10 (I definitely did it). Scoring is based upon the summation of responses, and computing the mean. With these alterations the Perceived Self-efficacy Scale, is essentially a list of possible post abortion coping reactions while yielding the degree to which women have experienced these reactions.

Impact of Event Scale (IES). A scale designed to assess the conscious subjective distress of how traumatic an event may have been, by measuring how intrusive the thoughts of that event can be. This is based on the premise that a traumatic event may be mentally intrusive to a person's thoughts, and beyond their cognitive control. The scale was designed to measure "...the current degree of subjective impact experienced as a result of a specific event (Horowitz, et al., 1979)." The two subscales measures how intrusive a thought of the traumatic event is and the degree to which the person tries to cognitively avoid the thought of the specific event. Intrusion Subscale questions are direct e.g. I thought about it when I didn't mean to. Questions on the Avoidance Subscale ask specific questions such as; I stayed away from reminders of it. Subjects are then asked respond to the statements by checking one of the categorical responses: Not at all, rarely, sometimes, and often.

Psychometric investigation of the measure revealed a high positive correlation

when determining internal reliability. Split half reliability of the total scale was high (r= .86). A correlation of .42 (p=.0002) was demonstrated, indicating an association between the two distinct subscales. When responses to different types of events were compared, a high correlation was found. When used amongst different social classes and ethnic groups, the measure proved highly consistent (Intrusion cluster, Cronbach's alpha=.78; avoidance cluster, Cronbach's alpha= .82). Test-retest reliability= .87 for the entire scale; .89 for the intrusion cluster; and .79 for avoidance cluster. The mean amount of time between the defined traumatic event and the test administration was 25 weeks, with the greatest length of time at 136 weeks. For the purpose of this study, the Impact of Event Scale is a scale used to measure post abortion syndrome, which may have resulted from any or all of the abortions a woman may have had. This is in line with the symptomatology of persistent and uncontrolled re-experiencing of the abortion described by Speckhard and Rue (1992). In terms of a post abortion reaction, it is possible that a cumulative effect may occur for the multiple aborter, or one procedure may be more accessible to recall than others. The directions have been modified to have the subjects exclusively consider their abortions, when answering the questions.

Post-Procedure Questionnaire. A scale designed to investigate the level of grief experienced by the subjects during the abortion experience (Peppers, 1987). These questions were developed from an earlier study investigating grief subsequent to involuntary termination of pregnancy (Peppers & Knapp, 1980). This grief scale measures all aspects of the grief reaction including the physical, emotional, psychological and social components. Subjects are asked to rate themselves twice; recalling how they

felt after the abortion, and how they feel now. Subjects are asked to estimate their levels of experience on different components of grief on a scale from 1 (no problem) to 9 (extreme difficulty). Thirteen variables, such as difficulty in concentrating, loss of appetite, guilt, and anger were used to define the different components of grief. All selected answers are summated yielding three final scores; a total score for grief at time of abortion (grief then); current grief score (grief now), and grief resolution (grief then-grief now). The questionnaire was modified to refer to multiple procedures and a retrospective format.With respect to this study this Likert scale will be used to measure the level of grief amongst the three groups.

Emotions Questionnaire (EQ). A questionnaire developed by Adler (1975). Women were asked to rate the level of feeling for a list of 15 emotions both positive and negative, following their abortion procedure. Respondents may choose from a range of 1 "not at all" to 5 "extremely." Three factors are yielded one for socially based negative emotions (indicative of her social circumstances and fear of social disapproval), internally based negative emotions (indicative of her own personal feelings about the pregnancy), and positive emotions. What is unique in this questionnaire is the demonstration that women were capable of experiencing two opposing feelings independent of each other. That is, women were able to report feeling high levels of regret while also feeling happy. For this study the EQ will investigate post abortion reaction, which as indicated previously, included both negative and positive emotions.

Multiple Abortion Interview. This is an open ended, informal interview created by the author of this study. It is designed to ascertain a more comprehensive

understanding of what women are subjectively experiencing in the abortion experience. Qualitative measures are more capable of assessing what a phenomenon may mean to the individual (Turell, et al., 1990). Women who volunteered for the interview signed a consent form at the end of the structured interview. The consent form indicated a phone number and time that would allow the subject to be contacted. Participants were randomly selected. In general, questions focused on how they felt about the multiple abortions and the possible ways the procedures have affected them. In addition, subjects are asked to expound upon questions that reflect the three phases of the entire abortion experience.

Procedures

The investigator gave a 7 minute presentation at the end of a class (see Appendix B). This presentation was prescheduled at the instructor's preference. All males in the class were dismissed. The women listened to an introductory speech providing general instructions, which included information about the study, guaranteed confidentiality, and freedom not to participate in the survey, or to discontinue the survey at any time. Subjects were also told that their participation or refusal of participation would not affect their grades. The second page of the questionnaire packet consisted of a written consent for the women to sign; consisting of a written guarantee of confidentiality, freedom to participate, or terminate the study at any time (see Appendix C). The questionnaire also included a written modified version of the oral instructions (see Appendix B).

The questionnaire was then distributed to all women who agreed to participate. Subjects were asked to take the survey home and complete it within the week. Upon

completion, subjects were instructed to deposit the survey at a predesignated room, which contained a mailbox to place the survey. The room location was previously determined by the faculty liaison person established at each college. Women who have never had an abortion were offered the questionnaire, for their scrutiny. In this instance they are asked to return the unmarked study to the same room and box. Since all women were given a questionnaire anonymity as to who had a procedure was preserved. At the end of the questionnaire, there was be a second consent form inviting women to participate in an informal semi-structured interview (see Appendix C). This invitation asked women to leave their first name only, a time and date, and a telephone number where they can be reached. Upon completion of the classroom presentation subjects were thanked, given referrals if requested, and reminded of their right to confidentiality.

Subjects selected for the interview will be based only on their agreement to participate in interview. The experimenter called all the consenting subjects to arrange an interview either in person or on the telephone. All subjects recalled the questionnaire, and agreed to a phone interview that was scheduled at the time of the first phone call. Subjects were asked to select a time in which they would have ample privacy (approximately one hour). They were told that the interviewer was writing their responses. They were reminded of their confidentiality, and told that they could end the interview at any time. Upon completion of the interview, subjects were reminded of their confidentiality, and thanked.

Statistical Analyses Plan

Multivariate multilevel analysis of variance (MANOVA) is an inferential statistical

method based upon differences in the variances, used in instances of several independent variables and several dependent variables. In this study each domain: the pregnancy context, pregnancy resolution, and post abortion response consists of subjects' scores on several measures and subscales (dependent variables). Subjects' scores on these measures are compared. The comparison is based upon the subject is a single, repeater, or multiple aborter (independent variable).

Analysis of Variance (ANOVA) is the comparison of variances of a single variable with multiple levels upon one dependent variable, used to test the null hypothesis.

The Scheffe test is a post hoc comparison test used to examine a contrast after the data has been analyzed.

T-test of independent samples is an inferential statistical method based on comparisons of the means of two groups, to determine if two groups are independent of each other. In this case the two groups being compared are the consecutive multiple aborters and the nonconsecutive multiple aborters. A t-test will be done based on the partner influence and post abortion response scales.

Principal components analysis and reliability analysis will be used to evaluate or rewrite the original measures in order to improve the psychometric properties for this sample. In addition this will help establish subscales and principal factors relevant to this sample.

RESULTS

The purpose of this exploratory and retrospective study was to investigate the experience of women who have had multiple abortions in comparison to women who have had one or two procedures. The goal was to determine whether the experience of multiple abortion may be classified into a separate and distinct phenomenon. The advantage of this retrospective format is that it does provide information regarding long term effects of multiple procedures. Adler, et al., (1990) has proposed that this is an area which necessitates further inquiry, since there is speculation regarding the confirmation of long term effects. In addition, women with different and more severe post abortion responses are more likely to respond because of the imposed distance created by the time factor, since prior research had demonstrated that women with more severe psychological sequelae are less likely to participate in studies (Adler, 1976).

The strategy of the study was to divide the entire abortion experience into three separate time phases: the pregnancy context, the decision making context and the post abortion response. In this chapter the results of the study are organized into 9 headings: Sample description, subgroup description, the findings of the six original proposed hypotheses, and supplemental analyses.

Sample Description

Six hundred questionnaires were distributed to six City University undergraduate school locations. Three locations were traditional four year colleges, and the other three were special sites designed to address the needs of the full time employed undergraduate students.

The response rate was 15.8% which resulted in 95 questionnaires returned, of which 71 were completed and used in the final statistical analysis. The 15.8% response rate surpassed the suggested 10% response rate typical of anonymous mail-in questionnaires suggested by Moser and Kalton (1972). Twenty four questionnaires were omitted due to incompleteness, or because respondent did not meet the study criteria. For example, some had experienced involuntary abortions, and some had abortion procedures performed outside of a regulated medical setting.

Descriptive analyses revealed that participants (N=71), had a mean age of 30.76. The minimum and maximum age was 18 and 54, respectively (SD=8.56, Mdn=30). Age groups were represented in the following manner; 2 were within the 18-19 age range (2.8%); 33 subjects (46.5%) fell in the 20-29 age bracket; 25 women (35.2%) were in their thirties; 9 women (12.7%) were in their forties; 2 subjects were in their fifties comprising the eldest age group (2.8%).

The religious affiliations of the subjects were as follows: 21 (29.6%) were Catholic; 18 (25.4%) women were members of different Protestant groups; 4 (5.6%) of the subjects were Jewish; 10 (14.1%) ascribed to their own "personal versions" of Christianity; 1 (1.4%) referred to herself as nondenominational; 1 (1.4%) was Hindu; 1 1 (1.4%) was Buddhist; 1 (1.4%) practiced Yoruba; 8 (11.3%) specifically stated that they did not belong to a religious group and 6 (8.5%) subjects did not respond to the question. In terms of practicing their religion, 23 (32.4%) women indicated that they practice their religion, 23 (32.4%) sometimes practice their religion, while 19 (26.8%) said they did not practice. 6 (8.4%) women did not respond.

Educational levels varied, due to subjects taking extra questionnaires for other women they knew. The majority of subjects (n=52, 73.2%) had some undergraduate college education. The remaining educational levels are as follows: n=3 (4.2%) had some high school; n=2 (2.8%) had received GED's; 1 woman (1.4%) had completed high school; 7 (9.9%) were college graduates; 1 subject (1.4%) had some graduate school; n=4 (5.6%) had completed graduate school; and 1 woman (1.4%) went beyond the post graduate level (PhD/MD). Subjects reported a mean household annual income of $20,000-$29,000, although the modal income fell in the $30,000-$49,000 income bracket (n=22). Fifty-seven (80.3%) were currently employed either full time or part time, and 14 (19.7%) were unemployed.

In terms of ethnodemographics, statistical analyses revealed a prototypical sample of women reflective of the City University of New York system and the ethnic diversity of New York City. Fifty-four (76.1%) subjects were born on the United States mainland. Subjects born outside (n=17) of the United States were divided by geographical regions: 4 subjects born in the English-Caribbean comprised 5.6% of the total group. Six spanish-caribbean born subjects composed 8.5% of the subject pool. Four (5.6%) women were born in Europe, and 2 (2.8%) were born in Central America. One (1.4%) subject did not respond to the question. Of those born outside the United States mainland the mean number of years in the United States was 17.94 (Mdn=18 yrs). The minimum number of years was 5 and the maximum was 36 years (SD=10.07). The ethnic/racial identification of the sample consisted of 29 (40.8%) subjects of African descent; n=19 (26.8%) were Hispanic; n=18 (25.4%) were of European descent; n=2 (2.8%) were Asian

and n=1 (1.4%) was Native American. A total n=2 (2.8%) did not respond to the question.

Analysis of relationship status revealed 22 (31%) of subjects were single; 21 (29.6%) were currently married; 3 (4.2%) were divorced; 3 (4.2%) were currently separated; 10 (14.1%) were living with someone; 1 (1.4%) were remarried; 10 (14.1%) were in long term relationships but not living with their partner; and 1 (1.4%) did not answer.

Subjects were asked to provide information regarding their reproductive history. Subjects were asked the total number of pregnancies they have had: n=19 (26.8%) reported one pregnancy; n=16 (22.5%) had two pregnancies; n=13 (18.3%) had 3-4 pregnancies; n=15 (21.2%) had 5-6 pregnancies; n=3 (4.2%) experienced 7-9 pregnancies, n=3 (4.2%) had 10-11 pregnancies, and n=1 (1.4%) had 16 pregnancies. One (1.4%) did not answer the question. Of those pregnancies, 15 (21.1%) resulted in one full term birth, n=12 (16.9%) resulted in two full term births. Six (8.4%) reported 3-4 fullterm births. Thirteen (18.3%) did not respond to the question. Inquiry into current primary birth control methods revealed that condoms was the most frequently used method, n=20, 28.2%). A total of 16 (22.5%) subjects did not use any method. Withdrawal was used by 10 (14.1%) subjects. Oral contraceptives was used by 8 (11.3%) subjects. Abstinence and tubal ligation were each used by 4 (5.6%) subjects. Three (4.2%) subjects used some other method, e.g. depovera. Methods such as diaphragm, sponge, IUD, calendar method all had a n=1 (1.4%) each. Only one subject did not respond.

All subjects were asked to respond to questions about their first trimester abortions.

Subjects reported a mean of 2.11 abortions, with a SD=1.94. The range of the number of abortions for one subject was 13 (minimum=1 and maximum=14). The number of years since the last abortion approximately 6 years ($\tilde{X}$=6.42). The average age subjects underwent their last abortion procedure was 24.32 years.

Subgroup Description

Subjects were divided into three groups, based on the number of abortions they have had. The single aborter group consisted of n=39 (54.9%) subjects. The repeater group consisted of 11 (15.5%) subjects. The multiple aborter group had an n=21 (29.6%). The demographics are reported in the following manner sociodemographics, ethnodemographics and reproductive demographics. The demographic distribution of the three subgroups are presented in Tables 1-10.

TABLE 1a

Age by Mean and Standard Deviation of the Single, Repeater and Multiple Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Variable	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Age	28.23	8.49	31.36	8.77	35.14	6.94

TABLE 1b

Age Groups by Percentage and Subgroup Total of the Single, Repeater and Multiple Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Age groups	**%age**	**n**	**%age**	**n**	**%age**	**n**
18-19	5.1	2	00	00	00	00
20-29	61.5	24	45.5	5	19.0	4
30-39	7.9	7	36.4	4	66.7	14
40-49	12.8	5	18.2	2	9.5	2
50-59	2.6	1	00	00	4.8	1

TABLE 2

Religious Affiliation and Religious Practice of the Single, Repeater, and Multiple Aborter Groups

	GROUP					
	single (n=39)		**repeater (n=11)**		**multiple (n=21)**	
Religious Groups	**%age**	**n**	**%age**	**n**	**%age**	**n**
Catholicism	35.9	14	18.2	2	23.8	5
Jewish	7.7	3	9.1	1	00	00
Protestant Faiths	20.5	8	18.2	2	38.1	8
Hindu	2.6	1	00	00	00	00
Personal version of Christianity	10.3	4	18.2	2	19	4
Yoruba	00	00	00	00	4.8	1
Buddhist	00	00	9.1	1	00	00
Nondenominational	2.6	1	00	00	00	00
None	12.8	5	9.1	1	4.8	1
Practice Religion						
Yes	25.6	10	36.4	4	42.9	9
No	33.3	13	18.2	2	19	4
Sometimes	33.3	13	27.3	3	33.3	7
No Response	7.7	9	18.2	2	4.8	1

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question.

TABLE 3

Educational Level of the Three Aborter Groups

	GROUP single (n=39)		repeater (n=11)		multiple (n=21)	
Educational Level	**%age**	**n**	**%age**	**n**	**%age**	**n**
Some High School	5.1	2	00	00	4.8	1
GED	2.6	1	00	00	4.8	1
High School Graduate	2.6	1	00	00	00	00
Some College	82.1	32	81.8	9	52.4	11
College Graduate	5.1	2	9.1	1	19	4
MA/Graduate School	2.6	1	9.1	1	14.3	3
PhD/MD	00	00	00	00	4.8	1

TABLE 4

Household Income of the Three Aborter Groups

	GROUP single (n=39)		repeater (n=11)		multiple (n=21)	
Household Income Level	**%age**	**n**	**%age**	**n**	**%age**	**n**
Under $5,000	12.8	5	9.1	1	4.8	1
$5,000-9,999	00	00	00	00	4.8	1
$10,000-14,999	5.1	2	9.1	1	4.8	1
$15,000-19,999	10.3	4	18.2	2	00	0
$20,000-29,999	17.9	7	27.3	3	28.6	6
$30,000-49,999	28.2	11	36.4	4	33.3	7
$50,000-74,999	15.4	6	00	00	9.5	2
$75,000-99,999	2.6	1	00	00	9.5	2
Above $100,000	00	00	00	00	4.8	1

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question.

TABLE 5a

Employment Percentages of the Three Aborter Groups

	GROUP					
	single (n=39)		**repeater (n=11)**		**multiple (n=21)**	
Employment	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Currently Employed	76.9% (n=30)	23.1% (n=9)	100% (n=11)	00% (n=0)	76.2% (n=16)	23.8% (n=5)

TABLE 5b

Employment Status of the Three Aborter Groups

	GROUP					
	single (n=39)		**repeater (n=11)**		**multiple (n=21)**	
Employment Status	**F/T**	**P/T**	**F/T**	**P/T**	**F/T**	**P/T**
Job Time	48.7 (n=19)	25.6 (n=10)	81.8 (n=9)	18.2 (n=2)	66.7 (n=14)	9.5 (n=2)

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question.

TABLE 6

Relationship Status of the Three Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Type of Relationship	**%age**	**n**	**%age**	**n**	**%age**	**n**
Single	41	16	27.3	3	14.3	3
Married	20.5	8	18.2	2	52.4	11
Living with someone	15.4	6	18.2	2	9.5	2
Long term relationship/not living	17.9	7	9.1	1	9.5	2
Separated	2.6	1	9.1	1	4.8	1
Divorced	00	00	9.1	1	9.5	2
Widowed	00	00	00	00	00	00
Remarried	00	00	9.1	1	00	00

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question.

TABLE 7a

Birthplace of Single, Repeater and Multiple Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Region Born In	**%age**	**n**	**%age**	**n**	**%age**	**n**
USA	71.8	28	81.8	9	81.0	17
English-Caribbean	7.7	3	00	00	4.8	1
Spanish-Caribbean	10.3	4	9.1	1	4.8	1
Europe	7.7	3	00	00	4.8	1
Central America	2.6	1	9.1	1	00	00

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question.

TABLE 7b

Mean Number of Years in the USA of Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Variable	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Years in the USA	14.09	8.97	21.00	4.24	29.52	5.76

TABLE 8

Racial and Ethnic Identification of Single, Repeater and Multiple Aborter Groups

	GROUP					
	single (n=21)		repeater (n=39)		multiple (n=11)	
Racial/Ethnic Group	**%age**	**n**	**%age**	**n**	**%age**	**n**
Hispanic Descent	28.2	11	45.5	5	14.3	3
African Descent	38.5	15	18.2	2	57.1	12
Caucasian/European Descent	25.6	10	27.3	3	23.8	5
Asian	5.1	2	00	00	4.8	1

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question.

TABLE 9

Reproductive Demographics of Single, Repeater, and Multiple Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Reproductive Event	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Total Number of Pregnancies	4.79	15.62	3.00	1.26	6.10	3.08
Number of Full Term Births	.83	1.28	.89	.93	1.40	.99
Years since Last Abortion	6.61	5.69	6.44	3.94	6.10	5.51
Mean Age at Last Abortion	21.16	5.08	26.67	7.25	29.52	5.76

TABLE 10

Current Methods of Birth Control Amongst Single, Repeater, and Multiple Aborter Groups

	GROUP					
	single (n=39)		repeater (n=11)		multiple (n=21)	
Primary Method of Birth Control	**%age**	**n**	**%age**	**n**	**%age**	**n**
None	20.5	8	18.2	2	28.6	6
Withdrawal	15.4	6	9.1	1	14.3	3
Condom	30.8	12	27.3	3	23.8	5
Oral Contraceptives	12.8	5	27.3	3	00	00
Diaphragm	2.6	1	00	00	00	00
Sponge	2.6	1	00	00	00	00
IUD	2.6	1	00	00	00	00
Tubal Ligation	7.7	3	9.1	1	00	00
Abstinence	00	00	9.1	1	14.3	3
Calendar Method	00	00	00	00	4.8	1
Norplant	2.6	1	00	00	00	00
Other	00	00	00	00	14.3	3

+++"n" columns may not be equal to the total n of each subgroup due to subjects who did not respond to the question

Original Hypotheses

The initial five hypotheses of this investigation was divided into three time phases of the entire abortion experience: the conception and pregnancy context which involves the subject's initial feelings about the pregnancy, the decision making context addresses the actual decision process to abort, and the post abortion response described as the emotional and behavioral aftermath subsequent to the procedures. The final hypothesis investigates the effect of consecutive procedures amongst the multiple aborter group.

Conception and Pregnancy Context

Hypothesis 1: Ambivalent Feelings towards the Pregnancy

It is likely that most women have feelings of ambivalence regarding how wanted or intended a pregnancy is. It was postulated that the multiple aborter group would be more likely than the single and repeater subgroup to report higher levels of ambivalence towards the pregnancy as measured by each of the scales. The conception and pregnancy context investigates thoughts about the actual pregnancy and conception. It has been determined in the previous literature review that if a pregnancy is planned or wanted these feelings will influence whether or not a woman chooses aborts and how she responds to the procedure. A number of measures were used to assess the various aspects of ambivalence including the Intendedness Scale, the Wantedness Scale, the Blame Subscale, and the Maternal Attitude Questionnaire. All results are represented in tables 11-13.

Table 11 represents the results of two one-way analysis of variance that were carried out to test hypothesis 1 with respect to scores on the intendedness and wantedness subscales. The analyses revealed that the three groups were quite similar with respect to

their $\bar{X}$ scores on each of these two measures, and neither F tests were significant.

TABLE 11

One-way Analyses of Variance of Intendedness and Wantedness Scales by Aborter Groups

	GROUP						
	single (n=39)		repeater (n=11)		multiple (n=21)		F
	Mean	SD	Mean	SD	Mean	SD	(2, 68)
Intendedness	3.89	.74	3.83	.69	3.74	.56	.35
Wantedness	2.94	.42	2.95	.37	3.03	.42	.37

(no significant differences)

A multivariate analysis of variance was performed in order to compare the three aborter groups on the 5 possible variables of the Blame Subscale in which the pregnancy was blamed on either chance, the situation, self-character, self-behavior, or blamed on another person. A multivariate analysis of variance was used in order to guard against the cumulative probability of a Type I error associated with multiple dependent variables. The multivariate tests indicate that there was no significant difference between the means of the three groups with respect to the five subscales. Univariate tests were also utilized replicating similar non- significant results as the multivariate results. Table 12 represents the details of these analyses.

TABLE 12

Multivariate and Univariate Analyses of Variance of Blame Variables by Aborter Groups

Multivariate Test:

Pillais	Hypothesis df	Error df	F
.16	10	124	.36

(no significant differences)

Univariate Tests:

	GROUP						
	Single (n=37)		Repeater (n=11)		Multiple (n=21)		F
Blame Subscale	Mean	SD	Mean	SD	Mean	SD	(2, 68)
Situational	3.76	2.65	5.40	2.46	3.86	2.59	1.63
Self-Behavior	5.46	2.05	5.80	1.99	5.19	2.25	.29
Chance	1.38	1.21	1.40	.97	2.24	2.10	2.32
Self-Character	2.81	2.34	2.00	1.56	3.24	2.55	.97
Other Person	2.27	2.04	2.80	2.44	2.24	2.00	.29

(no significant differences)

Analyses of the final measure of the conception and pregnancy phase is the Maternal Attitude Questionnaire, which results in three scores: the desired aspects of mothering, undesired aspects of being a mother, and a net score (desired-undesired aspects). For this study, reliability analysis was performed revealing reliability alpha coefficients of .96 for the Desired maternity subscale, and .93 for the undesired maternity subscale, the net score reliability alpha coefficient = .92. These reliability alpha

coefficients are similar to the ones found by the original author during the validation of the measure. One way analysis of variance revealed no significant differences between groups on the positive and negative aspects of mother [Positive Subscale: F(2,68)=2.59, n.s.; Negative Subscale: F(2,68)=2.45,n.s.]. Table 13 reveals the results with respect to the net score which revealed a significant difference amongst the groups [F (2,68)=3.64, p<.05].

TABLE 13

One-way Analysis of Variance of Net Score of the Maternal Attitude Questionnaire by Aborter Group

	GROUP						
	Single (n=37)		Repeater (n=11)		Multiple (n=21)		F
Maternal Attitude	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**(2, 68)**
Net Score	.41	.98	-.53	1.22	.42	1.18	3.64*

(* p.<.05)

Post hoc Scheffe contrasts indicated that there was a single significant pair-wise difference between the mean of single aborter (.41) and the mean of repeater group (-.53). The mean of the single aborter group was significantly higher than the repeater group indicating that the repeater group reported greater negativity regarding maternal motivation. It may be noted that the mean of the multiple aborter group (.42) is actually higher than the mean of the single aborter group (.41), however the pair-wise difference between the multiple aborter group and the repeater group was not significant. This is due to the smaller number of cases in the multiple abortion group as compared to the single group. Had the multiple aborter group been larger a significant difference may

have been found.

The first research hypothesis had limited statistical support regarding the different aspects of ambivalence. There were no significant differences in the intendedness and wantedness of a pregnancy and no significant differences with respect to attribution of blame for the pregnancy, thereby no differences in those aspects of ambivalence. A significant difference was found in the net score of the Maternal Motivation Questionnaire where the repeaters demonstrated a greater overall negative view of maternal motivation.

Decision Making Phase

Reproductive decision making has been well researched. Clearly, once pregnant, a woman is limited in terms of choices and the time allotted to make her decision. Many factors influence the decision. The decision making phase contains four factors: 1) those personal factors which influenced her decision; 2) how the woman actually feels about the abortion issue; and 3) the level of influence from the conceptor. Personal factors were measured by the Abortion Decision Questionnaire (ADQII). The Reasoning about Abortion Questionnaire (RAQ) assesses how the subject feels about the abortion issue itself. The Interpersonal Influence Survey (IIS) investigates the level of influence a partner may have with a subject's decision making. The social support subscale measures the perceived level of support from significant others.

Hypothesis 2: Ambivalence of Abortion

This paper proposed that multiple aborters would be more ambivalent about their beliefs about abortion.

In order to develop a parsimonious set of scaled scores representing the Abortion Decision Questionnaire, a principal components analysis with varimax rotation was performed. This analysis yielded 8 factors with eigen values greater than 1.00, however the Scree criteria suggested that only the first three factors would be valid for interpretation. Factors 4-8 were omitted since they were deemed uninterpretable. The loadings pertaining to factor one were ADQII items 14, 22, 20, 17, 23. All of these items dealt with negative aspects of the decision making process involving reasons to have or not have the procedure; e.g.: "part of me felt it was wrong to have an abortion or, I was worried an abortion would upset me afterwards." This factor was referred to the negative factor of the decision. The second factor had it's highest loadings on items that indicated quality of life issues of the abortion decision making process irrespective of the subject's choice (referred to as the positive factor). Items 6, 10, 12, 7, 13 loaded heavily on the positive factor; e.g "our life together was already satisfactory or, we both were ready for a baby anyway." Only two items had their highest loadings on the third factor which dealt with the economic consequences resulting from having a child (referred to as the economic factor). Items 1 and 2: "having a baby then would have prevented me from working/going to school and I could not afford a baby." Cluster scores were calculated for each of these three factors using just those items that had their highest loadings on each of the factors. Reliabilities were then calculated and produced alpha coefficients of .81 for the negative factor, .66 for the positive factor, and .71 for the economic factor.

A multivariate analysis of variance was then executed to compare the single, repeater, and multiple aborter group on the three factors; negative, positive and economic

factors. Table 14 represents the results of the analyses, which yielded no significant differences, between the means of the three groups on the factors which affect decision making.

TABLE 14

Multivariate Analysis of Variance of the Abortion Decision Question Factors by Aborter Group

Pillais	Hypothesis df	Error df	F
.13	6.00	116.00	.24

(no significant differences)

The Reasoning about Abortion Questionnaire examined subjects' personal deliberation on the abortion issue. Along one end of a continuum are personal reasoners; those likely to believe that abortion is a personal choice. On the other end of the continuum are moral reasoners, those who believe that abortion is morally wrong. Ambivalence is assumed if subjects did undergo a procedure, yet held opinions synonymous to pro-life advocates.

A principal components analysis with varimax rotation was performed in order to develop a set of subscales consistent for this sample. Variables loaded on three factors. Factor one consisted of those items that were consistent with moral reasoners (pro-life position). Items that loaded heavily on factor two were indicative of personal reasoners (pro-choice position). Revealed in this sample, was a third factor which indicated subjects' feelings about how a child would impact upon their lives. Table 15 represents the operative segment of the rotated factor matrix for this analysis of the RAQ, and the reliability alpha coefficients for the three factors.

TABLE 15

Rotated Factor Matrix and Reliability Alpha Coefficients for Reasoning About Abortion Questionnaire

VARIABLE	Loadings on Factors 1	2	3	Reliability Alpha Coefficients
2) Abortion is a threat to society.	**.69**	-.34	-.27	
4) Only God, not people can decide if a fetus should live.	**.73**	-.23	.20	
5) Even if one believes that there may be some exceptions, abortion is still basically wrong.	**.76**	-.11	-.50	
6) Abortion violates an unborn person's fundamental right to life.	**.88**	-.21	-.15	
10) Abortion is morally unacceptable and unjustified.	**.53**	-.30	-.61	
12) Abortion an be described as taking a life unjustly.	**.69**	-.17	-.37	
15) Abortion could destroy the sanctity of motherhood.	**.68**	-.24	-.07	
16) An unborn fetus is a viable human being with rights.	**.84**	-.12	-.09	
18) Abortion is the destruction of one life for the convenience of another.	**.83**	-.18	-.002	
19) Abortion is the same as murder.	**.83**	-.33	-.19	
Factor 1: moral reasoners				**.95**
1) Abortion is a matter of personal choice.	-.10	**.82**	.19	
3) A woman should have control over what is happening to her own body by having the option to choose abortion.	-.28	**.67**	.20	

TABLE 15 continued

	Factors 1	2	3	
7) A woman should be able to exercise her rights to self-determination by choosing to have an abortion.	-.30	**.84**	.16	
8) Outlawing abortion could take away a woman's sense of self and personal autonomy.	-.20	**.85**	.05	
9) Outlawing abortion violates a woman's civil rights.	-.31	**.84**	.12	
13) A woman should have the right to decide to have an abortion based on her own life circumstances.	-.18	**.70**	.31	
20) Even if one believes that abortion is wrong, it is still a woman's right to choose whether or not to have one.	-.17	**.85**	.17	
Factor 2: personal reasoners				**.93**
14) If a woman feels that having a child might ruin her life, she should consider abortion.	-.13	.28	**.81**	
17) If a woman feels she can't care for a baby, she should be able to have an abortion.	-.39	.27	**.72**	
Factor 3: Impact of child				**.72**

[item 11 was not included since it loaded negatively on to a factor by itself, and reliability could not be computed.]

A multivariate analysis of variance was executed to compare the single, repeater, and multiple aborter group on the three factors; moral reasoners, personal reasoners, and

impact of a child. The results of the analyses did not yield statistically significant differences between the means of the three groups with respect to the three factors, although one of the subscales did approach significance. Univariate tests revealed that the three groups differed with respect to the means of the moral reasoning factor. The repeater group were the least likely to have a pro-life attitude. Table 16 presents the results of these analyses.

TABLE 16

Multivariate and Univariate Analyses of Variance of Reasoning about Abortion Subscales by Aborter Group

Multivariate Test:

Pillais	Hypothesis df	Error df	F
.17	6.00	134.00	.059+++

(+++approaches statistical significance)

Univariate Tests:

	GROUP						
Reasoning about Abortion Questionnaire	**Single (n=37)**		**Repeater (n=11)**		**Multiple (n=21)**		**F (2, 68)**
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	
Moral Reasoners	24.87	10.71	16.46	6.51	21.57	10.99	3.02+++
Personal Reasoners	31.36	4.62	33.73	2.24	29.43	8.35	2.06
Impact of Child Reasoners	7.4	1.97	8.09	2.39	7.52	2.06	.47

(+++approached statistical significance: $p<.055$)

Statistical analyses revealed limited support for the second hypothesis; multiple

aborters experience greater ambivalence towards abortion. The three aborter groups were similar in personal factors used to decide upon choosing an abortion. Statistical significance would have been demonstrated on the Moral Reasoner subscale, if the N were larger. The analysis revealed that the single and multiple aborter group were higher moral reasoners than the repeater group.

Hypothesis 3: Partner Influence

A one-way analysis of variance was performed in order to investigate hypothesis 3, which proposed that multiple aborters were more likely to be influenced by their partners in decision making than the single and repeat aborters. The degree of partner influence was measured by the Interpersonal Influence Survey (IIS). The total scores on the IIS were compared using a F-test, and yielded no significant differences between the three groups [$F(2, 67)=.35$, n.s.]. All three groups were similar in terms of the level of partner influence they allowed in their individual decision making, thereby voiding hypothesis 3.

Hypothesis 4: Social Support of the Abortion Experience

It was hypothesized that multiple aborters would perceive their partners/conceptors as the most supportive of the entire abortion experience, as compared to the single and repeater group. Subjects were asked in six separate questions to rate partner, family, and friend support during the decision making phase and the post abortion response phase of their abortions. A principal components analysis with varimax rotation was performed to create a combined set of scaled scores which resulted in three factors with eigen values

greater than 1.00. The loadings pertaining to factor one were items DQ34 and SS16. These items deal with family support during both phases of the abortion experience. An overall score of family support was determined by computing the $\overline{X}$ of items DQ34 and SS16, and is referred to as the family mean. The second factor had its highest loadings with items DQ35 and SS17 which refer to support from friends during the decision making and post abortion response phase. The $\overline{X}$ score of those two items was computed for each subject and is referred to as the friend mean. Items DQ33 and DQ15 loaded heavily on factor 3 which involved partner support, and the overall partner mean was computed from the $\overline{X}$ of those two items. Reliabilities were calculated and produced alpha coefficients of .84 for the family support factor, .78 for the friend support factor, and .62 for the partner support factor.

A univariate analysis of variance was used in order to compare the three groups on the different types of support. Multivariate tests could not be used due to the linearly dependent relationship between family support and friendship support. The results of the three one way analyses of variances are indicated in table 17. As indicated the results of the analyses proved non-significant revealing that the three groups were similar in terms of how they perceived the three types of support.

TABLE 17

One Way Analysis of Variance of Family, Friend and Partner Support Subscales by Aborter Group

	GROUP						
	single (n=39)		repeater (n=11)		multiple (n=21)		F
Overall Support	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**(2, 68)**
Family Support	4.45	2.80	4.05	3.29	4.52	2.56	.113
Friend Support	4.45	2.80	4.05	3.29	4.52	2.56	.113
Partner Support	4.03	2.37	3.86	2.34	4.31	1.91	.173

(No significant differences)

Post Abortion Response Phase

Hypothesis 5: Subsequent Emotional Response

It was hypothesized that the multiple aborter group would be more likely than the single and repeater subgroup to report more negative and severe post abortion responses as measured by each of the scales. Post abortion reaction characteristically includes relief, depression and minor guilt. It may be more severe, resulting in greater negative emotions such as depression, guilt and confusion. Post abortion syndrome is further along the severity continuum consisting of reoccurring intrusive thoughts about the abortion and strong grief and quilt feelings. Two measures were used to evaluate the various aspects of post abortion reaction. The Perceived Self-Efficacy Scale (PSES) and the Emotional Questionnaire (EQ) both measure the characteristic emotional response subsequent to an abortion. The level of grief was measured by the Post Procedure Questionnaire (PPQ), and the Impact of Event Scale (IES) measured post abortion syndrome.

A principal components analysis with varimax rotation was performed on the PSES yielding 2 factors with eigen values greater than 1.00. These two factors were not noted by the original authors. Table 18 represents the operative segment of the rotated factor matrix for this analysis of the PSES. It presents those items which had their highest loading on factors 1 and 2. The loadings pertaining to factor one were PSES items 1-5 and item 7, these items described activities of daily living. Factor 2 had the highest loadings from item 6 and 8-10, which described activities related to the actual abortion. In addition, the total score of all items was used to assess the overall emotional aftermath. Reliabilities were calculated and produced alpha coefficients of .85 for the activities of living factor, .66 for the activities around the abortion factor, and .87 for the total PSES score. The two factors revealed by the principal components analysis are presented in Table 18:

TABLE 18

Rotated Factor Matrix for Perceived Self-Efficacy Scale

Variable	Loading on Factor 1	Loading on Factor 2
1) Carry on your normal school/work activities.	**.61**	.39
2) Thought about children/babies comfortably (not be upset or think about them too much or avoid thinking about them)?	**.58**	.51
3) Though about future pregnancy/pregnancies comfortably (not be upset or overly-worried about it or not think about it at all)?	**.76**	.34
4) Kept up a good relationship(s) with your boyfriend(s)/husband(s)?	**.74**	-.05
5) Spend time around children/babies comfortably (not be upset or spend too much time or avoid them)?	**.73**	.42
7) Continue to have good sexual relations?	**.75**	.13
6) Drive past facility where you had the abortion(s), or come into the building?	.20	**.85**
8) Watched TV shows or read newspaper/magazine stories about abortion.	.32	**.71**
9) Have a comfortable day on the anniversary(ies) of your abortion(s)?	.12	**.87**
10) Talk to your friends about your abortion(s)?	.11	**.57**

Univariate analyses of variances were performed on both factors and the total score in order to compare the three groups. Results yielded no significant differences between the groups with respect to the two subscales and the total scores [Activities of living factor, $F(2,68)=1.13$, n.s.; Activities around abortion factor, $F(2,68)=.44$, n.s.; and PSES

total score, F(2,68)=.23, n.s.).

The Emotions Questionnaire was also used to measure post abortion reaction. A principal components analysis with varimax rotation was performed on the Emotions Questionnaire yielding 3 factors with eigen values greater than 1.00, and subsequent reliability alpha coefficients above .55. The factors found in this study were different from those established by the original author. Table 19 provides the exact values and reliability alpha coefficients for the three factors. These factors were consistent with what was typical of post abortion reaction simultaneous opposing feelings; negative feelings, positive feelings and feelings of self-control.

TABLE 19

Rotated Factor Matrix and Reliability Alpha Coefficients for Emotions Questionnaire

Variable	Loadings on Factor 1	Factor 2	Factor 3	Reliability Alpha Coefficient
1) anxious	**.61**	-.04	-.03	
3) embarrassed	**.83**	-.13	.04	
5) regretful	**.61**	-.15	-.14	
6) guilty	**.79**	-.13	.-20	
8) ashamed	**.86**	-.18	-.02	
9) fearing disapproval	**.83**	-.07	.18	
11) angry	**.75**	-.12	-.27	
12) depressed	**.82**	-.19	-.27	
14) doubtful	**.77**	-.08	-.16	
15) disappointed in self	**.86**	-.17	-.14	
Factor 1: negative feelings				**.95**
2) in control	-.23	**.81**	.04	
10) competent	-.15	**.86**	.09	
Factor 2: Feelings of Self-Control				**.58**
4) proud	-.16	.09	**.83**	
13) happy	-.02	.05	**.79**	
Factor 3: positive feelings				**.69**
Total items: 16				**.83**

[item 7 was not included since it loaded negatively on to a factor by itself, and reliability could not be computed.]

Multivariate analysis of variance was utilized in order to compare the three aborter groups on the three subscales of the Emotions Questionnaire; Negative feelings, positive feelings, and feelings of self control. A multivariate analysis of variance was used in order to guard against the cumulative probability of a Type I error associated with multiple dependent variables. The multivariate tests indicate that there was no significant difference between the groups with respect to the three subscales consisting of the different post abortion reactions. Table 20 provides the statistical results.

TABLE 20

Multivariate Analysis of Variance Test of Emotions Questionnaire

Pillais	Hypothesis df	Error df	F
.043	6	134	.813

(no significant differences)

The Post Procedure Questionnaire was used to measure grief subsequent to the abortion procedure amongst the three groups. The questionnaire examines the level of grief at the time of the procedures (grief then) and currently (grief now). Reliability alpha coefficients revealed an alpha = .94 for grief then subscale and for the grief now subscale alpha =.95. In addition, a total grief score with a reliability alpha coefficient =.95, was computed in order to determine grief resolution (grief then-grief now).

Due to the linear dependency amongst the three factors multivariate analysis of variances were not utilized and univariate analyses of variances were performed. Table 21 represents the results of the analyses, which yielded no significant difference between the groups with respect to grief at the time of the abortions, current grief concerning the

abortions, and grief resolution.

TABLE 21

Univariate Analyses of Variances of Post Procedure Questionnaire

	GROUP						
Post Procedure Questionnaire Subscales	**single (n=39)**		**repeater (n=11)**		**multiple (n=21)**		**F (2, 68)**
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	
Grief then	69.97	28.38	64.55	28.80	63.14	29.20	.40
Grief now	32.92	22.75	23.00	14.96	33.14	26.26	.89
Grief Resolution	36.74	23.28	41.55	23.64	30.00	23.02	1.01

(no significant differences)

The Impact of Event Scale (IES) was used to measure post abortion syndrome. In this study, it was postulated that multiple aborters would experience a more severe post abortion syndrome than the single and repeater groups. A total score of the IES was calculated by computing a mean for all 15 items, yielding a total stress score. The reliability alpha coefficient for all 15 items yielded an alpha coefficient = .93. A principal components analysis with varimax rotation was performed on the IES yielding 2 factors with eigen values greater than 1.00. The intrusion and avoidance factors were consistent with the symptoms of intrusive and avoidant thoughts which are indicative of post abortion syndrome. The intrusion factor included those items which expressed the idea that the subject would unintentionally think about the abortion. The avoidance factor included items that suggested the subject would make conscious efforts to abstain from thinking about the abortion. Table 21 indicates which items correspond to each factor. Reliability alpha coefficients were computed for the intrusion and avoidance factors,

yielding an alpha coefficient = .94; and an alpha coefficient = .88 for each factor respectively. These reliability coefficients are consistent with what the original author found in the development phase of the scale.

TABLE 22

Rotated Factor Matrix for the Impact of Event Scale

VARIABLE	Loadings on Factor 1	Loadings on Factor 2
4) I had trouble falling asleep, because of pictures or thoughts that came to my mind.	**.81**	.21
5) I had waves of strong feelings about it.	**.78**	.36
6) I had dreams about it.	**.86**	.18
10) Pictures about it popped into my mind.	**.79**	.29
11) Other things kept making me think about it.	**.80**	.21
12) I was aware that I still had a lot of feelings about it.	**.75**	.44
14) Any reminder brought back feelings about it.	**.81**	.42
1) I thought about it when I didn't mean to.	.49	**.55**
2) I avoided letting myself get upset when I thought about it or was reminded of it.	.35	**.68**
3) I tried to remove it from memory.	.11	**.70**
7) I stayed away from reminders of it.	.43	**.64**
8) I felt as if it hadn't happened or wasn't real.	.22	**.66**
9) I tried not to talk about it.	.23	**.74**
13) I tried not to think about it.	.40	**.78**
15) My feelings about it were kind of numb.	.17	**.66**

Univariate analyses of variances were computed for all three factors due to the three factors being linearly dependent. The analyses revealed that there is no difference between groups in their responses to the IES total stress score, the intrusion factor and avoidant factor thereby nullifying the post abortion syndrome aspect of hypothesis 6. Table 22 illustrates the statistical results of the analyses.

TABLE 23

One Way Analysis of Variance of Impact of Event Scale Factors by Aborter Group

	GROUP						
Impact of Event Scale	**single (n=39)**		**repeater (n=11)**		**multiple (n=21)**		**F (2, 68)**
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	
Avoidance Factor	2.00	.85	2.39	.93	2.11	.90	.87
Intrusion Factor	1.92	.90	1.71	.92	1.87	.89	.21
Total Stress Score	3.91	1.64	4.10	1.74	3.94	1.54	.05

(no significant differences)

In conclusion the fifth research hypothesis had no statistical support. There was no significant differences in the Perceived Self Efficacy Scale (including factors of activities of living and activities around the abortion) and the Emotions Questionnaire and it's factors (positive feelings, negative feelings and feelings of self-control) thereby no difference in post abortion reaction amongst the three groups. There were no significant differences with respect to the different aspects of grief (grief then, grief now, and grief resolution) of the Post Procedure Questionnaire. In addition, statistical analysis of post abortion syndrome as measured by the Impact of Event Scale (avoidance factor, intrusion

factor, and total stress score) proved that the groups were similar.

Hypothesis 6: Within Group Analyses of Multiple Aborter Group: Consecutive vs. Nonconsecutive Multiple Aborters

The sixth research hypothesis focused on within groups differences of the multiple aborter group between those who had at least three consecutive voluntary first trimester abortions (consecutives, n=14) and those who have not had three consecutive procedures (nonconsecutives, n=7). It was hypothesized that the consecutive multiple aborters would be more ambivalent with regard to the pregnancy and abortion, are more likely to incorporate partner influence, perceive greater partner support, and have more severe post abortion responses, than nonconsecutive multiple aborters.

Ambivalence towards the Pregnancy

The conception and pregnancy context was again evaluated by looking at the various aspects of ambivalence using the Intendedness and Wantedness scales, the Blame subscales, and the Maternal Attitude Questionnaire.

Individual t-tests were performed in order to evaluate the intendedness and wantedness of the pregnancy. Results indicate that there was no difference between the consecutive and nonconsecutives with respect to how intentional the pregnancy was ($t=.45$, $p>.05$, n.s.). Similarly, the groups were not different in how wanted their pregnancies were ($t=1.22$, $p>.05$, n.s.).

A multivariate analysis of variance was executed in order to compare the two aborter groups on the 5 possible variables of the Blame Subscale in which the pregnancy was blamed on chance, the situation, the self-character, the self-behavior, or other person's

blame. A multivariate analysis of variance was used in order to guard against the cumulative probability of a Type I error associated with multiple dependent variables. The multivariate tests indicate a significant difference between the groups with respect to the five subscales. Univariate tests revealed that the consecutive multiple aborters were more likely than the nonconsecutive aborters to blame the cause of their pregnancy on their own behavior. Table 24 represents the details of these analyses.

TABLE 24

Multivariate and Univariate Analyses of Variance of Blame Subscales by Consecutive and Nonconsecutive Multiple Aborter Groups

Multivariate Test:

Pillais	Hypothesis df	Error df	Sig. of F
.64	5.00	15.00	.005***

(*** statistical significance)

Univariate Analyses of Variance

	GROUP				
	Nonconsecutive (n=7)		Consecutive (n=14)		F
BLAME SUBSCALE	**Mean**	**SD**	**Mean**	**SD**	**(1, 19)**
Situation	4.86	2.04	3.36	2.76	1.61
Self Behavior	3.29	2.06	6.14	1.70	11.46***
Chance (Bad Luck)	2.71	2.22	2.00	2.08	.53
Self Character	3.71	2.70	3.00	2.54	.36
Other Person	2.43	2.30	2.14	1.92	.09

(*** p<.003)

The Maternal Attitude Questionnaire was used to assess the positive and negative aspects of maternal motivation, and a net score (desired-undesired aspects). Univariate tests revealed no significant differences between consecutive and non-consecutive multiple aborters on the positive and negative aspects, or the net score of mothering [Positive Subscale: $F(1, 19)=2.65$, n.s.; Negative Subscale: $F(1, 19)=.05$,n.s.; Net Score $F(1, 19)=.93$, n.s.].

The different aspects of ambivalence during the pregnancy and conception phase had limited statistical support with respect to consecutive and non-consecutive multiple aborters. There was no significant differences in the intendedness and wantedness of a pregnancy. The two multiple aborter groups were also similar on how motivated and unmotivated they were about being a mother. thereby no difference in ambivalence towards the pregnancy. There was a significant difference with respect to attribution of blame for the pregnancy. Consecutive multiple aborters were more likely to blame the cause of their pregnancies as consequence of their own behavior.

Ambivalence about Abortion

Consecutive multiple aborters were not distinct from non-consecutive multiple aborters with respect to their ambivalence toward the abortion procedure. Separate multivariate statistical analyses of variance of the subscales of the Reasoning about Abortion Questionnaire (RAQ) and the Abortion Decision Questionnaire (ADQII) resulted in non-significant results as indicated in Table 25a and 25b:

TABLE 25a

Multivariate Analysis of Variance of Reasoning about Abortion Questionnaire by Consecutive and Non-consecutive Multiple Aborters

Pillais	Hypothesis df	Error df	F
.08	3.00	17.00	.687

(no significant differences)

TABLE 25b

Multivariate Analysis of Variance of Abortion Decision Questionnaire by Consecutive and Non-consecutive Multiple Aborters

Pillais	Hypothesis df	Error df	F
.13	3.00	17.00	.498

(no significant differences)

Partner Influence

A t-test revealed that consecutive and non-consecutive multiple aborters were distinct, in the degree to which they are influenced by their partners when making a decision. Analysis of this aspect of hypothesis 6 is statistically validated; consecutive multiple aborters were more likely than non-consecutive multiple aborters to be influenced by their partner in decision making. Table 26 represents those results:

TABLE 26:

T-test of Interpersonal Influence Survey by Consecutive and Nonconsecutive Multiple Aborters

Group	Mean	SD	t value
Non-consecutive	111.14	55.19	-2.25**
Consecutive	152.93	30.66	

(**p.<.036)

Partner Support

Univariate analysis of variance was utilized to investigate this aspect of hypothesis 6; consecutive multiple aborters would perceive partner support to a greater degree than non-consecutive aborters. Analyses shows no support for this ($F(1, 19) = .22$, n.s.). Thus, the two groups are not different in their perception of partner support. They did not see their partners as more supportive as compared to other significant people in their lives.

Post Abortion Responses

It was postulated that the occurrence of consecutive multiple abortions would result in a more severe post abortion response than non-consecutive multiple abortions. Individual t-tests were performed to evaluate this aspect of hypothesis 6, using the same measures and subscales that were previously used in this study. Results of these analyses reveal that the two groups are not distinct from each other regarding post abortion reaction, grief response or post abortion syndrome. Table 27 reflects these results.

TABLE 27

T-tests of Post Abortion Response Measures and Subscales of Nonconsecutive and Consecutive Multiple Aborters

	GROUP				
	Nonconsecutive (n=7)		Consecutive (n=14)		
Post Abortion Responses	**Mean**	**SD**	**Mean**	**SD**	**t score**
Post Abortion Reaction					
Perceived Self-Efficacy Scale:					
Activities of Living Subscale	5.50	2.87	6.82	2.47	-1.10
Activities around Abortion Subscale	6.50	3.01	6.95	2.94	-.33
Perceived Self-Efficacy Total	5.90	2.28	6.87	2.30	-.91
Emotions Questionnaire:					
Negative Feelings Subscale	3.00	1.20	2.35	1.33	1.09
Self-Control Subscale	3.07	1.46	3.50	1.19	-.72
Positive Feelings Subscale	1.14	.38	1.71	1.14	-1.28
Grief Response					
Post Procedure Questionnaire:					
Grief Then Subscale	77.57	22.52	55.93	30.16	1.67
Grief Now Subscale	37.86	23.44	30.79	28.09	.57
Grief Resolution	39.71	23.34	25.14	22.09	1.40
Post Abortion Syndrome					
Impact of Event Scale:					
Intrusive Thoughts Subscale	1.86	.86	1.88	.94	-.05
Avoidance of Thoughts Subscale	2.35	.98	1.99	.86	.88

(no significant differences)

Supplementary Analyses

In an attempt to isolate the experimental group, multiple aborters the single and repeater aborter groups were collapsed into one control group. All of the measures with respect to the different contexts of the abortion experience were then statistically analyzed, comparing the multiple's to the combined single and repeater group. Only one significant result was found. A one way ANOVA yielded a single significant comparison of the two groups on the chance variable of the Blame Subscale. The $\overline{X}$ score of the multiple aborter group (2.24) was significantly different from the $\overline{X}$ (1.38) of the collapsed single and repeater group. This is more in the hypothesized direction that multiple aborters were more likely to attribute the pregnancy to bad luck or out of their control then the collapsed single and repeat aborter group.

TABLE 28

Univariate F-test of Blame Subscales by Collapsed Single, Repeater and Multiple Aborter Group

	GROUP				
	Single and Repeater (n=47)		Multiple (n=21)		F
Blame Subscale	**Mean**	**SD**	**Mean**	**SD**	**(1, 66)**
Situation	4.11	2.67	3.86	2.60	.13
Self-Behavior	5.53	2.02	5.19	2.25	.39
Chance	1.38	1.15	2.24	2.10	4.70**
Character	2.64	2.21	3.24	2.55	.97
Other Person	2.38	2.11	2.24	2.00	.07

(** p.<.034)

The three aborter groups were compared on number of years since the last abortion and the age at their last abortion. One way analysis of variance was performed in order to compare the three groups in each instance. The results revealed no significant differences between the three groups in how many years since their last procedure ($F(2, 65)=.06$, n.s.). Significant differences were found amongst the three groups with respect to the age at the last procedure ($F(2,65)=15.03$, $p<.001$). Post hoc Scheffe contrasts indicated that the mean of single aborter (21.16) was significantly lower than the mean age of the repeater group (26.67) and the mean age of the multiple aborter group (29.05).

TABLE 29

One-way Analysis of Variance of Age at Last Abortion by Aborter Group

	GROUP						
	Single (n=38)		Repeater (n=9)		Multiple (n=21)		F
Variable	Mean	SD	Mean	SD	Mean	SD	(2, 65)
Age at Last Abortion	21.16	5.08	26.67	7.25	29.05	5.33	15.03***

(*** p.<.001)

Responses to Multiple Abortion Interview

The Multiple Abortion Interview was administered to 8 consenting multiple aborters and 5 single aborters. Initially, 11 multiple aborters had volunteered, but due to conflicting schedules with the interviewer three interviews could not be arranged. Subjects were given the option of either a phone or in person interview. Only one woman requested an in person interview, while the other seven preferred phone interviews. Only

the contents of the multiple aborter interviews will be examined in the discussion section of this paper.

Conclusion

The significant findings of the quantitative measures used in this study will be summarized in the context of the entire abortion experience. In terms of the conception and pregnancy context the only aspect of ambivalence which revealed significant results was pregnancy attribution as measured by the Blame Subscale and maternal motivation as measured by the Maternal Attitude Questionnaire (MAQ). Consecutive multiple aborters were found to be significantly more likely than nonconsecutive multiple aborters to attribute the cause of their pregnancies to their own behavior. In addition, repeaters were found to have a significantly lower net score on the Maternal Attitude Questionnaire.

In terms of the different components of the decision making context, limited significant results were found. Statistical significance was found when comparing consecutive multiple aborters to nonconsecutive multiples on the level of partner influence. The consecutive multiple aborter group reported a greater level of partner influence in their decision making. Statistical significance was approached when the three groups were compared on the Reasoning about Abortion Questionnaire, revealing that repeaters were significantly lower on the moral reasoning subscale, than the other two groups.

In addition, supplemental analyses revealed that multiple aborters were significantly older at the time of their last procedure than the single and repeater groups. Multiple aborters when compared to the combined single and repeater group were more

likely to attribute their pregnancies to chance.

Overall, principal components analyses provided consistent results similar to those determined by the original authors. On three of the measures (RAQ, PSES, and EQ) principal component analyses exposed additional subscales that were not reported by the original authors. These additional subscales are reflective of the sample used in this study, urban women of color, college students. Most of the original measures were developed in the 1970's and 1980's. These additional subscales reveal a shift in the issues that are pertinent to the way women currently think about abortion.

DISCUSSION

In general, it was hypothesized that women who have undergone multiple abortions experienced a more ambivalent and negative abortion experience. This was suggested in the preceding literature review, based on the extrapolation of research findings regarding the single and repeat aborter. Overall, the hypotheses in this dissertation had minimal statistical support.

In this final section, the author will summarize and interpret the results of the statistical analyses, in hopes of drawing inferences and implications from the research. Suggestions for clinical implications, limitations of this study, and future research will also be explored. To reiterate, the purpose of this exploratory retrospective study was to investigate the entire abortion experience as it is perceived by women who have undergone single, repeat, or multiple first trimester voluntary abortions. The entire abortion experience was defined in three phases; the conception and pregnancy context, the decision making context, and the post abortion responses. Based on the work of others (Adler, 1992; Miller, 1980; Peppers, 1987; Turell, et al., 1990), a major premise assumed in this paper is that these three phases are interdependent and determine how the woman perceives her abortion experience. That is, problems in one context will cause problems in another context, thus affecting the entire abortion experience. The questionnaire used in this study, and the hypotheses reflect these three phases. The majority of subjects consisted of predominantly urban, female college students, who consented to the confidential lengthy questionnaire which consisted of open and closed ended questions. In addition, a subsample of the subject pool consented to a confidential

phone interview consisting of open ended questions reflective of the three phases.

Pregnancy and Conception Context

Hypothesis 1: Ambivalence towards the Pregnancy

When looking at the conception and pregnancy context, it was proposed that women who have undergone multiple procedures would experience greater feelings of ambivalence towards the actual pregnancies. On most of the protocols used to measure attitudes toward the pregnancy, it was found that all the women in the study had the similar levels of ambivalence toward the pregnancy, regardless of the number of abortions they had. These findings suggest that greater ambivalence is not a factor contributing to the multiple aborter's experience.

When measuring maternal motivation, the repeater group was found to have a significantly greater negative attitude toward maternal motivation, than the single or multiple aborter group. The scores of the single and multiple aborter group reported similar and greater positive aspects of maternal motivation. This may reflect greater ambivalence since women were asked to only concentrate on those pregnancies that resulted in first trimester abortion. Given the higher, positive maternal motivation, ambivalence may have been induced since these women felt more positive about mothering.

Decision Making Phase

Hypothesis 2: Ambivalence of Abortion

Multiple aborters were not found to be different in how they felt about the

personal factors which influence the actual abortion decision. All three groups were similar when compared on how they assess quality of life issues, negative factors, and economic factors in their decision making process regarding their abortions.

There is some evidence that ambivalence towards abortion may occur for the multiple aborter when looking at personal opinions and their reasoning about how they feel about the abortion issue. Multiple and single aborters had opinions which reflected more of a pro-life (anti-abortion) sentiment, as opposed to repeaters who indicated more of a pro-choice (pro-choice) sentiment. Given the greater anti-abortion sentiment of the multiple and single aborter groups, one could speculate that these women may have experienced greater conflict and ambivalence about their abortions, since she decided to abort a pregnancy, despite feeling that abortion is not the most ethical procedure.

Hypothesis 3: Partner Influence

Multiple aborters were no more likely than the other two groups to rely on their partner's influence in their decision making. Given the previous finding that the multiple aborters were not significantly more ambivalent in their feelings about the pregnancy (hypothesis 1), these findings does not negate the already stated premise that pregnancy ambivalence is related to a greater reliance the need for partner influence in the decision to abort (Adler, 1992; Miller, 1980; Turell, et al., 1990).

Hypothesis 4: Social Support of the Abortion Experience

Partners were perceived as no more supportive of the abortion experience, than were their families or friends, amongst the three aborter groups. When asked on the

Social Support Subscale (Major, et al, 1990; Mueller & Major, 1989) the degree of support during the abortion experience the respondents indicated mean response range of 3.86-4.52 with respect to the three types of support; partner, family or friends. Thus the type of relationship does not appear to be a major factor as to who the multiple aborter seeks support from. This is congruent with the findings of hypothesis 3, that is, their partners were seen as not influential in their decision to abort.

These results, that is the influence of the conceptor on the decision to abort and the degree of support perceived during the abortion experience are aspects of the heterosexual relationship. Evidence shows the multiple aborters are not distinguished by in these aspects of their relationships with the conceptor, as compared to the single and repeat aborters. These data indicate that the relationship between the conceptor and aborter are not significant factors in their abortion experiences.

One can conclude from the quantitative results of the different aspects of the decision making phase, (ambivalence over the procedure, partner support and influence) that the multiple group did not have problems in the decision making process concerning the abortions, and hence the decision making process cannot be implicated as a factor which would result in multiple abortions.

Post Abortion Response

Hypothesis 5: Post Abortion Response

The multiple aborter group did not undergo more negative post abortion responses than the other two groups. This study has determined that multiple abortion procedures are not more likely to induce greater and more severe post abortion reactions, or post

abortion syndrome. One can conclude from looking at subjects' current level of grief and grief resolution regarding the abortions that a delayed grief response or current grief reaction was not incurred by any of the groups. That is, since the mean number of years after their procedures was approximately 6 years for each group, all groups reported similar levels of current grief related to their abortions. In terms of the multiple aborter, this suggests that undergoing multiple procedures does not produce greater or longer lasting negative post abortion responses.

Hypothesis 6: Consecutive vs. Nonconsecutive Multiple Aborters

Finally, this paper proposed that women who have undergone consecutive multiple procedures were more likely than non-consecutive multiple aborters to have a greater negative abortion experience. Consecutive aborters did show some differences from non-consecutive aborters, only these significant findings will be referred to. When looking at the conception and pregnancy context, consecutive multiple aborters attributed their own behavior as the cause of their pregnancies. According to the authors of the Blame Scale (Major, 1985; Mueller & Major, 1989), self-behavior as an attribution to the cause of the pregnancy indicates an attribution of greater personal responsibility and indicative of a loss of self control. Therefore, they believe they could have initiated more self-control. One could then assume that these women felt a lack of control, since they had undergone multiple pregnancies and procedures.

In terms of the decision making context, consecutive aborters were more likely to be influenced by their partner's input. It may be suggested that since consecutive aborters feel more out of control in terms of pregnancy causation, and blame the pregnancy on

their own behavior, they may be looking at their partner's input as a way to help make their decision which would produce a greater sense of control and cohesion for their abortion experience.

It is suggested that consecutive multiple aborters waver in how they experience self-control. As noted they see the cause of their pregnancies as a result of a loss of not controlling their own behavior. This implies a sense of internal locus of control, since they believe it is possible to control one's own behavior. The consecutive and multiple pregnancies challenge their belief, which then causes the consecutive multiple aborters to look for their partner's input in their decisions, which is an external locus of control. This is consistent with Peppers (1987) finding; that women with an external loci of control, are more likely to be influenced by her partner's attitude.

Supplementary Analyses

Multiple aborters saw their pregnancies as a result of bad luck or chance more so than the single and repeat aborter group combined. Again, this suggests that multiple aborters do experience a lack of total control. In all of the other possible pregnancy causation attributions, (self-character blame, other person blame, etc.) there is some level of control that can be ascertained by the woman. The attribution of chance or bad luck is viewed as something serendipitous or as happenstance; an event completely outside of one's personal control. The notion of loss of control was previously raised by consecutive multiple aborters, as well. This suggests that the notion of control is a very important issue for women undergoing multiple unwanted pregnancies and abortions.

Multiple aborters were found to be significantly older at the time of their last

procedure than the single or repeater groups. This finding is similar to the findings of others (Aguirre, 1980; Berger, et al.,1984; Gibb & Millard; 1981). Since this group was older, they also have a longer reproductive history thus exposing them to a higher probability and greater frequency of reproductive events, including sexual intercourse. Tietze (1977) believed that given the longer reproductive histories, exposure to possible multiple abortions was inevitable, and a matter of statistical probability. In addition it can be assumed that these women are also likely to have a greater number of different types of relationships with the conceptors.

Multiple Abortion Interview

Most of the multiple aborters interviewed reported that there was at least one abortion experience that stood out in their memory. Several factors seemed to make these abortions significant; the quality and type of relationship with the conceptor, the level of support from significant others, the ordinal position of the abortion (usually the first procedure was prominent in recall), exposure to opposition (e.g. right to life groups at the clinic, family opposition), and level of alertness due to anesthesia. In addition, interview subjects reported different ways of recalling the different procedures or acknowledging the anniversaries of specific abortions. For example, one woman reported that the date of her first abortion was used as her personal identification number on her bank card. Other participants would recall their procedures when they would think about the relationship with the conceptor.

What was not revealed in the quantitative measures, appeared to be a major issue in the interviews, and that was the level of influence of the partner. During the interview

subjects were asked if they intended or wanted to get pregnant. Half of the respondents reported that they never intended or wanted to get pregnant at all. Others' responses were based upon the specific pregnancy. Of interest is that all the women who reported this, based their intention and wantedness of the pregnancy on the quality of relationship they were having with the conceptor, or the relationship's future potential.

The final question of the interview was the most revealing. Subjects were asked "Is there something you would like to add about your experience with the abortions?" Most of the multiple aborter summed up their experiences in phrases that reflected their feelings about all of their abortion experiences. One woman reported that the abortions were a reflection of a dark side of her self, which had the ability to go against nature. Another referred to her procedures as "a necessary tragedy." One subject referred to her abortions as "murder by self-defense." She further explained that she felt the need to have the procedures as a way of defending herself and the things she needed to do. While most women reported that they were doing fine, and didn't think their procedures affected them pathologically, these statements do reveal that the procedures had an impact.

Discussion of Findings

The findings in this study offer three possible conclusions for discussion. The first conclusion is that there is nothing unique about multiple aborters perception of the abortion experience that would cause them to undergo multiple procedures. Given the model of the abortion experience, and based on the lack of findings in this study there is little evidence to state that there is something unique about the way multiple aborters undergo the abortion experience as compared to the single and repeat aborter. The

minimal statistical evidence found in the hypotheses of the three different phases of the abortion experience argues for the conclusion that the process of undergoing multiple abortions is not considerably different than undergoing one or two procedures. That is, in terms of the ascribed abortion experience, multiple abortions is not a distinct and separate phenomenon.

The interaction and interdependence between the different phases of the abortion experience is further validated by the results of this study. The evidence provided by this study, demonstrated by the consistent lack of significant findings across the three phases further clarifies their interdependence. The fact that not one phase proved significantly different indicates that the abortion experience demonstrates a interdependence and consistency across the phases, in addition to a fairly similar entire abortion experience for all the groups.

The second conclusion suggests that the overall long term effects of multiple abortion are no different than single or repeated procedures, which is consistent with current research conclusions. Most research has looked at single aborters and found that the common negative effects and anxiety either occur before the procedure or are short term post procedurally (Adler, et al., 1990), and have little impact on overall psychological functioning (Robbins, 1979). Hence, post abortion reaction is typical of normal stress and coping that one may experience in any stressful event (Adler, et al., 1992). This study validates this normal coping response in that it did not find any significant findings in any aspect of the post abortion response phase in any of the three groups. This demonstrates that women undergoing multiple abortions are not subject to

greater distress or psychopathology. This is a significant non-finding, since many professionals and laymen assume that there is a cumulative negative effect of having several procedures. Most noticeable is that consecutive multiple aborters in this study did not indicate a greater degree of intrusive or avoidant thoughts indicating that they did not perceive greater stress or trauma as a result of having several consecutive procedures. This finding specifically addresses the premise of post abortion syndrome, which was previously described as a form of post-traumatic stress disorder involving repetitive and disturbing thoughts and behavioral re-enactments (Fisher, 1986; Horowitz & Becker, 1972; Speckhard & Rue, 1992).

The third deduction, involves the significant results regarding the consecutive aborter group. To reiterate, this group was found to have experienced some loss of self-control in terms of their own behavior with respect to pregnancy attribution, and to rely more on partner influence in their decision making processes. These findings are in the direction of the initial hypotheses and the work of others already cited in this paper. These findings provide evidence for a need to view abortion in terms of an entire process, due to the interdependence of the phases. Lind and Connole (1985) report that young girls are more subject to social influence since they are raised to assume less control of their own decision making, suggesting that women are cultivated to make decisions with assistance. In this study consecutive multiple aborters allowed more for partner influence. This affirms that consecutive multiple aborters allow to a greater degree for social influence and input in their decision making, possibly due to feeling a lack of control over their own behavior with regard to pregnancy cause.

Integration and Implication of Findings

Social Influence

The fact that the multiple aborter group was found to be significantly older at the time of their last procedure has several implications, besides being victims of statistical probability. One possibility is that multiple aborters have had more exposure to the vacillation of the social and legal history of abortion. Research has found that public opinion on abortion has gone from a liberal to a conservative view since the Roe v. Wade decision (Ebaugh & Haney, 1980). These authors also found that younger and older women had gone through a similar change in their attitudes on abortion, one could speculate that this change in opinion may have had an effect on the multiple aborter. In this study, single aborters (younger women) and multiple aborters (older women) both reported greater pro-life attitudes.

The initial individual decision making process according to sociocognition theorists, consists of the individual's attempt to make sense of social events by pooling information from the environment (Hastie & Pennington, 1991, p. 310). In addition the degree of change that a subject allows in their decision making is based on the quality of the influence (Kenny, 1993). Earlier in the literature review, it was suggested that individuals will gather information from their social environment, and use this information to make a decision or formulate their own opinion (Hastie & Pennington, 1991; Kenny, 1993). Given the ever changing public opinion on abortion and the fact that multiple aborters tend to be older, the information they have on abortion has shifted, possibly creating a need for partner influence in order to confirm their personal decisions. All of

the women who were individually interviewed for this study revealed responses contrary to the objective measures. They reported that their partners were influential in their decision making, to a certain degree. Many reported that this influence was not direct. Rather they would evaluate and refer to the quality of the relationship, his support or nonsupport of the pregnancy or abortion. Interestingly, many interviewees reported that when his opinion regarding the abortion differed from theirs, the women proceeded according to their own beliefs, usually without his knowledge.

Social influence also comes from a societal level. Evidence of the social influence from the environment is that all of the interviewed multiple aborters did state that there were only certain people who knew about their multiple procedures. All the interviewees stated there were people that they would never tell about the multiple procedures: specific family members such as mothers or children or current partners. The reasons for not telling were fear of ridicule, issues of privacy, and not wanting to upset the other person. This does suggest that the women felt that the multiple procedures would not be accepted by their social environment. This decision to proceed with the abortions and their decision not to inform significant others reflects the women's vacillation between two major opposing social opinions on abortion.

Reproductive Locus of Control

Locus of control as introduced by Rotter (1975) is the dimension of an individual's perception as to the level and type of control over his/her fate and outcomes. Much of the research looking at abortion and locus of control is contradictory and hence inconclusive (Gibb, 1984; Lester & Cook, 1988; Peppers, 1987; Thompson & Robinson,

1986). Given the discrepancy in the research, it is possible that the locus of control may not be the construct that is in operation in women's reproductive events. For example, Tinsley, et al., (1993), defined pregnancy related locus of control as the control over pregnancy outcome based upon a woman's pregnancy health beliefs and compliance with prenatal health guidelines. This author argues for a more specific construct: reproductive locus of control. At first glance, one would assume that reproductive locus of control is synonymous with birth control; the actual use of contraception. A more specific psychological construct may be in applicable: reproductive locus of control, which incorporates how the woman cognitively perceives her own ability to control all her reproductive events. Reproductive locus of control is an umbrella term with reproductive decision making, contraceptive decision making, pregnancy related locus of control, body locus of control, and reproductive goals falling underneath it.

Birth control is a specific control issue with multiple components. It includes deciding upon a contraceptive method, and attitudes and knowledge of different methods, all of which culminates in the actual physical act of selecting and using a contraception method. Much of the literature on causes of abortion refers to the level of consistent use and reliability of the contraceptive method (Faria, et al., 1985; Jacobsson, et al., 1976; & Tsoi, et al., 1987). Given the various results, contraception methods serve as only a small component of reproductive health care and is not sufficient in providing an explanation of multiple abortions. What was referred to as reproductive locus of control, occurs prior to contraception use. That is, women must perceive and cognitively organize the notion of psychological control over their reproductive abilities prior to using contraception, or

planning a pregnancy. Reproductive locus of control may help to explain why some women use less reliable methods, or are inconsistent with their current methods, or how women approach infertility issues.

The construct of reproductive locus of control is worth investigating. Multiple aborters and consecutive multiple aborters perceive themselves as out of control in terms of pregnancy attribution. This issue has always been a major concern for women, and has yet to remain in their hands, given the public outcry and politicization of birth control and abortion. This author interprets this as women feeling they have little right to control their own body, a result of the social influence of current culture. Steinhoff, et.al. (1978) suggested that social and personal factors impact upon contraceptive practices indeed resulting in repeat and multiple abortions. Brewer (1977) studied women in England who had 3 or more abortions. He reported findings that imply components of reproductive locus of control: abortion was not considered the preferred contraceptive technique; the primary reason for the third abortion was due to contraceptive failure. Multiple aborters had a much more erratic use of birth control. Erratic failure was defined as either the withdrawal method, or at least one unprotected intercourse between the second and third procedure.

A question in the Multiple Aborter Interview addresses the construct of reproductive locus of control. Subjects were asked "Do you feel that there is any reason that caused you to have several procedures?" Most women reported a lack of responsibility either with birth control or their own behavior. One subject reported that she was trained to hate her female body and her sexuality. As a result, her abortions

occurred during a period when she had no control over her body. This respondent felt that this self-hatred and lack of control resulted in her multiple procedures. One woman reported that the multiple procedures taught her to take more control over her own reproduction. Indeed these findings indicate that the suggested components of reproductive locus of control are important. There is no suggestion that the women felt these behaviors and acts contributed to the broader goal of controlling their reproductive histories, rather they viewed their actions as immediate with the need to terminate an unwanted pregnancy.

Professionals' Biases

". . . individuals are greatly influenced by the attitudes of politically significant others. . ." (Kenny, 1993, p. 565). Therapists and clinicians are subject to social influence as well, which contribute to their personal opinion of abortion. As stated previously, the political climate and social acceptance of abortion has fluctuated drastically. It is suggested that the political and social vacillation on the abortion issue does impact upon the personal and professional opinions of women's health care providers. This vacillation on abortion leaves most people with an opinion in either the pro-choice or anti-abortion camp. There is little public recognition or acceptance that people may hold supportive and negative views in both camps. The fact that there is no accepted public opinion or forum that supports a combined opinion on abortion may translate on an individual level as one of doubt or fluctuation in their personal opinions. It can be suggested that this lack of recognition of multiple or dual opposing opinions contributes to the negative opinion on multiple abortions held by most clinicians. This

negative opinion then translates and contributes to the pathological diagnoses of women who have undergone multiple procedures.

Fueling the biases concerning abortion, is the prevailing biases held against women. Therapists have been found to hold biases against women based on traditional sex and gender roles which is reinforced in their training, hence affecting treatment and diagnosis (Teri, 1982; Waisberg & Page, 1988; Weiner and Boss, 1985; Women and Therapy, 1984). Sherman, et al., (1978) found psychotherapists held on to stereotypical attitudes and information about women that were often contradictory to the attitudes and information provided by their women patients. These authors found that male therapists were the least informed on issues regarding the "psychology of female bodily functioning" (p.310) which includes issues of women's health and reproduction. When asked about abortion, male therapists were inclined to believe that women should not make the decision alone without some professional help. To further confuse matters these authors found, stereotypical feminine behaviors such as passivity and dependency were considered signs of pathology. These findings suggest that some forms of therapy work to maintain the traditionally lower status quo of women, by viewing those behaviors that vary from the male dominant status quo as either deviant or pathological.

When looking at abortion many conclude, (including women themselves) that the procedure is a clear step away from the traditionally passive role of women. The act of abortion is clearly a step in actively controlling reproduction, hence reproductive locus of control. Bowman (1982) found that therapists' bias did exist when evaluating women who were considered active instead of passive. Active women were seen to have more

intrapsychic or personality problems, whereas men with the same diagnosis were seen to have problems more a function of their interpersonal relationships. Similarly, Waisberg and Page (1988) found that therapists tended to view certain diagnoses as either masculine (e.g antisocial behavior or alcoholism) or feminine (depression or anxiety). If a patient were diagnosed with the opposite gender diagnosis, they were viewed as more pathological. If abortion is viewed as a nonconformist gender-role behavior, multiple abortions is then easily viewed as a pathological behavior.

This study has determined that the experience of undergoing multiple abortions is neither indicative of or produces psychopathology. Yet, the bias and labeling of multiple aborters persists. The findings in this study provide some direction in approaching the abortion issues for women's health care professionals and other clinicians.

Clinicians and therapists should investigate the entire abortion experience from the conception and pregnancy phase to the post abortion responses phase. The abortion experience should be looked at within the political and social context of the patient and the abortion debate. In addition, the level of social influence on the abortion experience on the patient should then be explored.

Professionals should be clear of their own biases towards women, abortion, and especially multiple aborters. Additionally, if a clinician vacillates on their opinion of abortion, the clinician should be aware of how this will affect diagnosis and treatment. Continuing education on women's issues would provide more clarity on how therapists have also held on to traditional sex and gender roles (Women and Therapy, 1984).

Pregnancy attribution, reproductive locus of control and pregnancy related locus

of control, should be part of the treatment when working with all abortion patients. The clinician should be cautious and vigilant of the patient's and their own opinion of pregnancy attribution. Consecutive and nonconsecutive multiple aborter are more likely to see their pregnancies due to lack of self-control as demonstrated in this study, and the therapists are likely to see the cause of pregnancy as women being too active. This represents incongruency in behavioral attribution, and could delay the treatment, or cause premature termination (Tracey, 1988).

Limitations of Present Study

There are several problems with this study, which when addressed may serve to enhance future studies. The length of the questionnaire was a complaint by many of the subjects, many of whom responded to the questionnaire during their busy academic year, and complained about the amount of time needed to finish it, and their lack of available time. The length of the questionnaire may have discouraged some potential respondents, thereby reducing the sample. Interestingly, despite the length many commented on the questionnaire as being a positive experience. For example; "I hadn't thought about my abortions in such a detailed way, it really made me think about them."

Subjects were asked to think about their abortions collectively, thereby grouping their abortion experiences into one collective experience. As noted, in the multiple interviews subjects reported that certain abortion experiences were more salient than others, which may have affected the quality of the response.

Another problem with this study is it's retrospective format, which could change the definition of certain variables. A retrospective design often results in subjects

experiencing different variables (Turell, et al., 1990). Women who are asked to recall previous abortion experiences are subject to recall error (Tietze & Bongaarts, 1982). Campbell, et al., (1988) felt that the perception of feelings could change over time. Rosenthal and Rosnow (1991) argue that it is difficult to recall memories which were originally surrounded in anxiety and fear. Burnell and Norfleet (1987) administered a questionnaire and survey of self-reported attitudes and adjustment after an abortion. They found that only 21% of their subject pool could recall their feelings at the time of the abortion. Christensen-Szalanski (1984) found that patient's preferences varied over time, and at certain periods these changes in preferences may not reflect one's long term goals. An example of this pertinent to this study is that many women who chose to abort as an immediate solution to a crisis, do intend and want to have children as a long term. In other words, the current decision to abort may be a favorable one if future prospects in parental investment look better (Hill & Low, 1992). In this study, many women who aborted do want and plan to have children in the long term, despite their immediate decision do abort.

In contrast, the advantage of this retrospective format is that it does provide information regarding long term effect of multiple procedures. Adler, et al., (1990) has proposed that this is an area which necessitates further inquiry, since there is speculation regarding the confirmation of long term effects. In addition, women with different and more severe post abortion responses are more likely to respond because of the imposed distance created by the time factor, since prior research has demonstrated that women with more severe psychological sequelae are less likely to participate in studies (Adler, 1976).

Recommendations for Future Study

Longitudinal Study

A way to eliminate the retrospective format and to monitor the variations factors due to time would be to repeat this study in a longitudinal format. The longitudinal design would entail following the same subjects as they undergo the entire abortion experience. The survey would be divided into the three phases and administered to subjects as they complete each of the phases. In this study the subjects experience would be less influenced by changes resulting from time.

Qualitative Analysis: a call for sensitive measures

Robbins (1979) found no relationship between subjective responses to questions about abortions and objective measures. This is consistent with what occurred in this study, and was most prevalent when conducting the individual interviews with the multiple aborters. While objective measures produced minimal results, the individual interviews provided revealing information and data about the decision making process and the post abortion response. In addition, the revelation of additional subscales in some of the measures used in this study, indicate a need to update present measures or to develop sensitive measures in order to capture the changing attitudes on abortion, and to reflect the cultural diversity of a population.

Consecutive Multiple Abortions

The fact that the consecutive multiple aborter group was the only group that reported some discrepancy in their experience of the abortion process, makes them a

group worth investigating further. This study provided only 14 consecutive aborters, so the information yielded is limited. A more extensive comparative study of consecutive multiple aborters and nonconsecutive multiple aborters would better address the issues and effects of consecutive procedures. Variables such as reproductive locus of control, social influence and decision making should be explored further. Another issue is the effect of consecutive multiple procedures on the decision making process: the question to be asked is how and why would consecutive multiple procedures impact upon the need for assistance in decision making. The study would also evaluate if partner influence is a negative or positive factor for women. Christensen-Szalanski (1984) suggested that experience does have an effect on one's value assessments, hence affecting their decisions. Thus, multiple aborters (consecutive and nonconsecutive) may enter the abortion experience with less anxiety and apprehension, thus having a clearer value assessment of the abortion experience. Given that clearer assessment, a valuable research project would be to measure the impact of the previous abortion on a subsequent one and on how the partner influences that decision.

Reproductive Locus of Control

Another study of interest would be to investigate the construct of reproductive locus of control. A review of the literature and a pilot study would help to validate the psychological construct of reproductive locus of control and the variables that are incorporated into it. Initially one could look at other areas of locus of control; reproductive goals, contraceptive use, pregnancy locus of control, and reproductive history (McKinney, et al, 1984).

Professionals' Biases

Bernstein (1982) found that clinical judgements of patients were more likely to be affected by therapist characteristics such as gender, profession, and level of training. She suggests that more research regarding other therapist characteristics and beliefs would be beneficial. With respect to this topic, this would include therapists attitudes toward abortion and multiple aborters. There are no studies in the psychological literature that look at clinicians and women's health care professionals and their personal opinion on abortion and the effect of their opinion in their treatment and diagnosis of multiple aborters. An appropriate research design would be to provide clinical vignettes to clinicians for the purpose of diagnosis and treatment planning. The paradigms would be similar, except with the provision that the patient had a certain number of abortions. Clinicians would be asked to provide a diagnosis and treatment and to explain their decisions based on the information provided in the vignette. In addition clinicians would be given a questionnaire such as the RAQ, which would investigate the clinicians attitudes toward abortion.

Summary and Conclusions

This study investigated the abortion experience of multiple aborters (n=21) to see if they are unique and distinct from women who have undergone one (n=39) or two (n=11) abortions. No major differences were found among the single, repeater and multiple aborter groups on quantitative measures. When consecutive multiple aborters were compared to nonconsecutive multiple aborters, issues in self control regarding pregnancy attribution and partner influence were found. Due to minimal statistical

support, it was concluded that there is nothing unique about the way multiple aborters go through the abortion experience, nor does multiple procedures produce significant negative psychological consequences. Qualitative measures consisting of individual interviews revealed that partners were influential in the decision making indirectly, such as the woman evaluating the quality of relationship, or evaluating his feelings towards the pregnancy. The third conclusion found is that the reliance on partner influence and other forms of social influence is a typical decision making strategy.

This study suggests that the biases held by laypersons and professionals against women who multiply abort are due to the social influences consisting of the fluctuating public opinion on abortion. It is recommended that this bias could be eliminated if womens' health care professionals 1) investigate the entire abortion experience of their multiple aborter patients; 2) be aware of their own biases against women; 3) explore the notion of reproductive locus of control with their patients.

APPENDIX A

INSTRUMENTS AND MEASURES

REPRODUCTIVE

HISTORY, CHOICES, AND OUTCOMES

SURVEY

Code Number_____

ADQ

Please fill in the blanks or circle the appropriate numbers. Note: All information is strictly confidential, no one will know your name or your answers to the questions.

1. How old are you? _____ years

2. What is your racial/ethnic background? _____

3. What country were you born in? _____

   3a. If you were born in another country how many years have you lived in the United States? _____

4. Your religion is _____

   4a. Do you practice your religion currently? (Please circle one)

   1. Yes
   2. No
   3. Sometimes

   4b. How important is religion in your life?

   1. Very important
   2. Somewhat important
   3. Not very important
   4. Not at all important

5. Years of education completed (Circle most recent answer)

   1. Some high school
   2. GED
   3. Vocational/technical School
   4. Graduated High School
   5. Some college (how many years total)_____
   6. College Graduate (4 year degree)
   7. Some Graduate School
   8. Masters Degree/Graduate School
   9. Ph.D/MD/Post Graduate

5a. If you were not educated in the United States, in what country was most of your education? _____

5b. How many years have you been enrolled in college in the United States?_____

6. Are you currently employed? Yes____ No____

6a. If employed, full time_____ or part time_____

7. In which of these groups did your total household income fall last year. This is your income from any source, and before taxes are taken out.

1. Under $5,000
2. $5000-9,999
3. $10,000- 14,999
4. $15,000- 19,999
5. $20,000- 29,999
6. $30,000- 49,999
7. $50,000-74,999
8. $75,000-99,999
9. Above $100,000

8. Are you currently:

1. Single
2. Married
3. Living with someone
4. In a long term relationship, but not living with the person
5. Separated
6. Divorced
7. Widowed
8. Remarried

9. Your **present** birth control method (Circle all that apply):

1. None
2. Withdrawal
3. Condom
4. Pill
5. Diaphragm
6. Sponge
7. Cervical Cap
8. IUD
9. Spermicides (Foam/Gel/Suppository/Cream)
10. Basal Body Temperature
11. Calendar Method
12. Abstinence
13. Tubal Ligation
14. Partner Sterilization
15. Norplant
16. Other_____(please write in)

10. Parity (Reproductive History)

a. How many times have you been pregnant in your life_____
b. Of these pregnancies: how many turned out to be:

i: Live full term births (write number here)_____
ii: Premature births_____
iii: Miscarriages (spontaneous abortions, 20 weeks or less)_____
iv: Abortions for Medical Reasons (mother or fetus)_____
v: Voluntary First Trimester Abortions_____
vi: Second trimester abortions_____
vii: Still Births (more than 20 wks pregnant) _____
viii: Currently Pregnant Yes_____ No_____

11. It is important to get a comprehensive understanding of your reproductive history and choices. One way to do this is to get the sequence of reproductive events, since this affects our lives. **Please think back, take your time and try to be accurate in your recall of past events.** Using your age and year of the event as the marker on the time line please write down the order of events of your reproductive history. Start on the left by writing when had your first period, then mark the first time you had intercourse, your age and year of each full term pregnancy, age and year of each second trimester abortion, age and year of each premature birth, year and age of each miscarriage (spontaneous abortions), age and year of each abortions for medical reasons (mother or fetus), age and year of each therapeutic or voluntary first trimester abortions, and age and year of each still birth. If more than one reproductive event happened to you in one year, then put things in the order that they occurred; things that happened earlier in the year go first before things that happened later in the year. Use the key below to make things easier

Menses=First Menstrual Period
LB=Live full term births
MISS=Miscarriages (spontaneous abortions)
SAL=Second trimester abortions
MED=Abortions for Medical Reasons (mother or fetus)
TP=Therapeutic/Voluntary First Trimester Abortions
FI=First Intercourse
Preemie=Premature births
SB=Still births
CP=Currently pregnant

Example: S had her first period at 14 in 1980. She had her first sexual intercourse at 19 in 1985, she became pregnant from that encounter but had a first trimester abortion. She had her first child in 1990, and a miscarriage two years later, then her second child in 1993, she became pregnant immediately after this and had another first trimester abortion in that year.

This is how S's story would look like on the time line.

Year	1980	1985	1990	1992	1993
Age	14	19	24	26	27
1st event	Menses	FI	LB	Miss	LB
2nd event		TP		TP	

Your time line is on the next page:

TIME LINE

Here is your time line. Please try to remember all of the reproductive events that have happened to you. Remember to begin with your first menstrual period, and include your first intercourse.

Menses=First Menstrual Period
LB= Live full term births
MISS=Miscarriages (spontaneous abortions)
SAL=Second trimester abortions
MED=Abortions for Medical Reasons (mother or fetus)
TP=Therapeutic/Voluntary First Trimester Abortions

FI=First Intercourse
Preemie=Premature births
SB=Still births
CP=Currently pregnant

Year_____

Age_____

1st event of year_____

2nd event of year_____

3rd event of year_____

4th event of year_____

5th event of year_____

6th event of year_____

7th event of year_____

12. From the time line, write down how many reproductive events happened consecutively

Live births you had in a row _____
Miscarriages you had in a row_____
Voluntary First Trimester Abortions (1-3 months of pregnancy) in a row ____
Second Trimester Abortions (3-6 months of pregnancy) in a row _____
Premature Births in a row _____
Still births in a row _____
Medical Abortions [mother or fetus] in a row_____

The remainder of the questionnaire asks questions about any and all the first trimester (the first three months of pregnancy) voluntary abortions that you may have had. Please answer the questions about your abortion(s) as accurately as possible. It is very difficult to think back, please try to be accurate in your memory of these past events.

13. Was/were your abortion(s) performed in the United States. Please write a yes or no in the space provided (if you have had more than 10 voluntary first trimester abortions please use the back of this page to write on)

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

14. Were any of your abortions performed before 1973? Please write a yes or a no n the line next to the procedure.

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

15. Did you have any children **before** you had the abortion(s)? Please write down the number of children you had **before** you had each of the abortions.

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

16. Was/were there any complications with any of your procedures? If so write down the complication (e.g. infection, perforation, hemorrhage, blood transfusion, exploratory surgery, partial procedure, etc.,). Please write it in the space next to the procedure.

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

17. In what type of facility was/were your abortions done: Please place the number of the corresponding facility next to the procedure

1. municipal/state/ public hospital
2. private hospital
3. free standing abortion clinic
4. private physician's office
5. other_____
(please explain)

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

18. After the abortion(s), did you go for the post abortion checkup? (Please write yes or no after the procedure).

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

19. After the abortion(s) did you use any type of birth control? (Place a yes or no after the specific procedure. If the answer is yes, then write the type of birth control next to the word yes)

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

20. Did anyone go with you to the procedure(s). If yes, write the name of the type of relationship of the person(s) who went with you to each procedure (e.g. mother, friend, boyfriend, husband, sister). If no one went with you write; no one. (If it was a different person but same type of relationship write for example; husband A or husband B)

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

21. For those pregnancies that ended up in an abortion, write the type of relationship that you had with the conceptor [the man who got you pregnant]. (For example: an extra marital affair, boyfriend, husband, fiancee, acquaintance, a rape, a lover, a one time sexual encounter, or you don't know etc.) If you got pregnant by the same person on several occasions, or, if you got pregnant by the same type of relationship, but they were different men then refer to them by the type of relationship plus a letter, for example boyfriend A or boyfriend B.

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

22. Of all your pregnancies that resulted in a first trimester voluntary abortion did you ever become pregnant by the same person more than once?

Yes_____ No_____

23. Of all your pregnancies that resulted in a first trimester voluntary abortion did you ever become pregnant by the same person more than two times?

Yes_____ No_____

CONCEPTION AND PREGNANCY CONTEXT

Code Number_____

II. This section is about the pregnancy/pregnancies prior to the abortion(s). This refers to the time period from the moment you thought you conceived to the period before you made the decision to have the abortion(s). Many of the questions have to do with the feelings and events that happened from the moment you thought you conceived, and for the time period that you were pregnant. **Please try to think back, and try to be accurate in your recall of the past events. Remember we are referring only to those pregnancies that resulted in a first trimester voluntary abortion.**

Below are a number of factors that you might feel were responsible for your being pregnant. That is, these are factors that you might blame for your pregnancy/pregnancies that resulted in an abortion(s). Some women feel that only one factor is to blame, other women feel that more than one factor is responsible for their pregnancies. Please indicate all factors that you feel are to blame. For each item, circle the number that indicated how much you feel that factor was to blame for your pregnancy/pregnancies.

1. I blame my pregnancy/pregnancies on the situation I was in at that time. (For example, my or my partner's birth control method failed, or my birth control method wasn't available on that occasion, or my judgments was affected by alcohol or drugs, or it was something else about the situation at that time.)

   not at all 1 2 3 4 5 6 7 very much

2. I think I am to blame for my pregnancy/pregnancies because of something that I did or didn't do. (For example, I didn't use birth control or used it incorrectly, or I put the possibility of pregnancy out of my mind, or I made a mistake in figuring when I was likely to get pregnant, or I used an ineffective method of birth control, or I did something else wrong.)

   not at all 1 2 3 4 5 6 7 very much

3. I think my pregnancy/pregnancies was the result of bad luck. (For example, I was just unlucky, so I got pregnant, or it was my fate to get pregnant it was some other kind of bad luck.)

   not at all 1 2 3 4 5 6 7 very much

4. I think I am to blame for my pregnancy/pregnancies because of the kind of person I am. (For example, I'm not responsible enough, or I have difficulty controlling myself, or I'm too trusting, or I'm not strong enough, or it's something else about the kind of person I am.)

not at all 1 2 3 4 5 6 7 very much

5. I think someone else is to blame for my pregnancy/pregnancies. (For example, my partner, or my parents, or my doctor, or someone else.)

not at all 1 2 3 4 5 6 7 very much

Intentionality

6. Overall, how much did you intend to get pregnant?

not at all 1 2 3 4 5 6 7 very much

7. Did you intend to become pregnant; that is did you hope or not hope to become pregnant. Place a **1** if you were motivated to conceive. Put a **2** if you felt conflicted about conceiving. Put a **3** if you felt very motivated not to conceive.

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

8. Even though your pregnancy/pregnancies resulted in an abortion(s), you may have tried to conceive. How planned was each of your pregnancies? That is, did you consciously decide to become pregnant (i.e. purposely choose not to use contraception, or seek a physician's help to become pregnant) or did you not think about pregnancy, or did you plan not to become pregnant (e.g. purposely chose to use contraception). Place a **1** if you did plan to conceive, a **2** if there was no planning to conceive, and a **3** if planned not to conceive. Place a **4** if you believe that you can not plan a pregnancy and it is beyond your control.

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

IS

Please answer these questions regarding **all the pregnancies that you had that resulted in a first trimester voluntary abortion. Remember that all your answers are confidential.**

9. During the time(s) around when you got pregnant, were you using any method of birth control at all?

   YES_____ NO_____

10. During the times when you were using no method of birth control, did you or your partner intend that you get pregnant?

    YES_____ NO_____

11. Although not intending to get pregnant, did you realize that by using no birth control you might very well get pregnant?

    YES_____ NO_____

    11a. and did you intend to have a(nother) child if you did get pregnant?

    YES_____ NO_____

12. Did you and your partner disagree with each other at all about your getting pregnant at that time?

    YES_____ NO_____

    12a. Which member of the relationship wanted the pregnancy? _____

    12b. Which member of the relationship did not want the pregnancy?_____

13. Did you have any mixed feelings or doubts about your getting pregnant at any time?

    YES_____ NO_____

14. During the pregnancy/pregnancies that resulted in an abortion(s), what method of birth control did you use, most of the time? (Circle all that apply)

IUD
Sterilization
Diaphragm
Condom
Foam
Rhythm method
Withdrawal
Pill
Partner Sterilization
Norplant
Douche
Calendar Method

15. How regularly were you using this method?

1. Used it with every sexual intercourse
2. Failed to use it on one occasion
3. Used it most of the time
4. Used it some of the time

16. How consistently were you taking the pill?

1. Never missed a pill
2. Missed occasional pill
3. Missed a series of pills (at least 3) only once, on the occasion that I got pregnant
4. Often missed 3 or 4 pills with each cycle
5. Never took the pill

17. How regularly were you protected by this method?

1. Always protected
2. Unprotected only once
3. Unprotected on several occasions

Many women report different feelings once they realize that they are pregnant, regardless of whether or not the pregnancy/pregnancies are maintained. **Try to think back about the pregnancy/pregnancies that resulted in a first trimester voluntary abortion, and how you felt right after you found out you were pregnant.**

18. Although you were taking some steps to prevent or avoid pregnancy, would you say it was alright with you if you got pregnant or would you say you definitely did not want to get pregnant?

    1. Alright that I got pregnant
    2. Definitely did not want to get pregnant
    3. Don't know

19. Overall, would you say then that you were definitely trying to become pregnant, willing to have a child whenever you got pregnant, or you did not want to get pregnant?

    1. Trying to get pregnant
    2. Willing to have children
    3. Did not want the pregnancy/pregnancies to happen
    4. Don't know

20. For those pregnancies that resulted in abortion, were there ever times that you felt that you had a half-conscious wish to get pregnant or have a baby, although you knew it was not practical.

    1. Agree completely
    2. Agree somewhat
    3. Disagree somewhat
    4. Disagree completely

21. There were times when I just didn't care whether or not I got pregnant.

    1. Agree completely
    2. Agree somewhat
    3. Disagree somewhat
    4. Disagree completely

22. I am the sort of woman who might have gotten pregnant just to hurt or punish myself.

    1. Agree completely
    2. Agree somewhat
    3. Disagree somewhat
    4. Disagree completely

23. When you <u>first</u> found out that you were pregnant, even though the pregnancy/pregnancies resulted in an abortion, how did you feel about being pregnant? For each pregnancy that resulted in a first trimester voluntary abortion, place a **1** if you were happy you were pregnant. Put a **2** if you felt conflicted about being pregnant. Put a **3** if you felt unhappy about being pregnant.

1st procedure_____	6th procedure_____
2nd procedure_____	7th procedure_____
3rd procedure_____	8th procedure_____
4th procedure_____	9th procedure_____
5th procedure_____	10th procedure_____

WS

Even though your pregnancy/pregnancies resulted in an abortion(s), you may have experienced different feelings while you were pregnant. Please circle the response that best explains how you felt about being pregnant.

24. Overall, what were your feelings about your being pregnant and having a child at the time when you determined that you were pregnant?

    1. wanted to be pregnant and have a child
    2. accepted being pregnant and having a child but would have preferred not to be pregnant and having a child at this time, if I could do it over again
    3. Rejected being pregnant and having a child and definitely planned either to obtain an abortion or give up the child after birth

25. Were there any important problems created for you by your being pregnant and having a baby at this time, including how your partner(s) felt?

    1. yes
    2. no

26. Overall, did you give some consideration to giving up the child(ren) after birth?

    1. Yes 2. No

The Conceptor

27. Was the man who impregnated you (got you pregnant) using birth control at the time you think you conceived? (Place a yes or no in the space after the procedure)

    1. Yes 2. No

1st procedure_____	6th procedure_____
2nd procedure_____	7th procedure_____
3rd procedure_____	8th procedure_____
4th procedure_____	9th procedure_____
5th procedure_____	10th procedure_____

28. What was the birth control method he was using? (Put the number next to the birth control method on the line next to the procedure)

    1. condom
    2. withdrawal
    3. vasectomy
    4. other (please specify)_____
    5. none

1st procedure_____	6th procedure_____
2nd procedure_____	7th procedure_____
3rd procedure_____	8th procedure_____
4th procedure_____	9th procedure_____
5th procedure_____	10th procedure_____

29. Overall, would you say it was alright with the man/men who impregnated you if you got pregnant, or would you say he/they definitely did not want you to get pregnant?

    1. Alright that you got pregnant
    2. Definitely did not want you to get pregnant
    3. Don't know

30. Overall, did the man/men who got you pregnant definitely want you to have a child, was he willing to have a child whenever you got pregnant, or he did not want a child?

    1. Definitely wanted to have a child
    2. Willing to have a child, whenever it happened
    3. Did not want to have a child
    4. You don't know

MAQ

Sometimes women may go through several different feelings prior to their decision to have an abortion. Many women think about how a pregnancy or a child will change their lives, or what it is like to be a mother. These ideas and feelings may reinforce or weaken their decision to have an abortion. **Think back to when you were pregnant, and before you had your abortion(s), see if you can remember any of these feelings while you were pregnant with those pregnancies that resulted in a first trimester voluntary abortion(s).**

We are interested in what there is about having children that is desirable to you and what there is that is undesirable to you. **Regardless of whether you have never had children, are in the middle of having your family, or have finished with childbearing, you will have feelings about what is good and what is bad about having children.** This questionnaire is designed to help us understand those feelings. It has two parts. One asks primarily about the desirable consequences of having children and the other asks primarily about the undesirable consequences.

Part I

On the left below and on the next three pages are listed some consequences of having children. Read over the list and indicate how desirable each one is to you by circling one of the four answers in the column on the right. If you feel that a consequence is very desirable, then circle the word "Very." for example:

Desirable Consequences	**How Desirable**			
A. Watching the growth and development of my child.	Very	Moderately	Slightly	Not

On the other hand, if you find that a consequence is not desirable, or that it does not apply to you enough for you to have some feelings about it, then circle the word "Not." For example:

Desirable Consequences	**How Desirable**			
B. Reliving my own childhood through my child.	Very	Moderately	Slightly	Not

Now go on to complete items 1 through 28, circling one of the four answers according to how you feel about having children.

Desirable Consequences	**How Desirable**			
1. Knowing that I am fertile.	Very	Moderately	Slightly	Not
2. Having my family and friends admire me with my baby.	Very	Moderately	Slightly	Not
3. Feeling a baby move and kick inside me.	Very	Moderately	Slightly	Not
4. Giving my husband/mate the satisfaction of fatherhood.	Very	Moderately	Slightly	Not
5. Giving birth to a baby.	Very	Moderately	Slightly	Not
6. Feeling needed and useful through my baby.	Very	Moderately	Slightly	Not
7. Breastfeeding a baby.	Very	Moderately	Slightly	Not
8. Having my child provide me with companionship and support later in life.	Very	Moderately	Slightly	Not
9. Having a helpless baby to love and protect.	Very	Moderately	Slightly	Not
10. Feeling more complete as a woman through my baby.	Very	Moderately	Slightly	Not
11. Holding a cuddling a baby.	Very	Moderately	Slightly	Not

Desirable Consequences	**How Desirable**			
12. Having a son.	Very	Moderately	Slightly	Not
13. Devoting myself and much of my time to raising children and being a mother.	Very	Moderately	Slightly	Not
14. Having a child who will carry on my family traditions.	Very	Moderately	Slightly	Not
15. Being the center of a large, active family.	Very	Moderately	Slightly	Not
16. Strengthening our relationship or marriage through a child.	Very	Moderately	Slightly	Not
17. Fulfilling my religious feelings about family life.	Very	Moderately	Slightly	Not
18. Having a daughter.	Very	Moderately	Slightly	Not
19. Having my child be a success in life.	Very	Moderately	Slightly	Not
20. Playing with my child.	Very	Moderately	Slightly	Not
21. Having my child contribute to society.	Very	Moderately	Slightly	Not
22. Guiding and teaching my child.	Very	Moderately	Slightly	Not
23. Sharing childraising with my husband.	Very	Moderately	Slightly	Not
24. Living a fuller, more enriched life through my child.	Very	Moderately	Slightly	Not
25. Providing my parents with a grandchild.	Very	Moderately	Slightly	Not
26. Fulfilling my potential by having children.	Very	Moderately	Slightly	Not

Desirable Consequences	**How Desirable**			
27. Experiencing the special love and closeness that a child provides.	Very	Moderately	Slightly	Not
28. Giving our other child(ren) a brother or sister.	Very	Moderately	Slightly	Not

PART II

In this part of the questionnaire we have listed some of the consequences of having children that can be undesirable. Use the same way of answering as in Part I, except remember that this time "very" means very **undesirable**, "moderately" means moderately **undesirable**, etc. Thus, if you feel that an item is very undesirable, circle the word "Very." For example:

Undesirable Consequences	**How Undesirable**			
A. Having a child who is unattractive.	Very	Moderately	Slightly	Not

Or, if you feel that an item is not undesirable or that it does not apply to you enough for you to have some feelings about it, then circle the word "Not." For example:

Undesirable Consequences	**How Undesirable**			
B. Having a child who is very active.	Very	Moderately	Slightly	Not

Now go on to complete the rest of the questionnaire.

Undesirable Consequences	**How Undesirable**			
1. Experiencing the discomforts of pregnancy.	Very	Moderately	Slightly	Not
2. Being kept from my career or job by a baby.	Very	Moderately	Slightly	Not
3. Straining our marriage or relationship with a baby.	Very	Moderately	Slightly	Not

Undesirable Consequences	How Undesirable			
4. Having an unhappy and poorly adjusted child.	Very	Moderately	Slightly	Not
5. Being responsible for a needy and demanding baby.	Very	Moderately	Slightly	Not
6. Having a baby who strains my health.	Very	Moderately	Slightly	Not
7. Spending time and energy involved in childcare.	Very	Moderately	Slightly	Not
8. Having to put up with the mess and noise that children make.	Very	Moderately	Slightly	Not
9. Burdening our family finances with a child.	Very	Moderately	Slightly	Not
10. Worrying about the health and safety of my child.	Very	Moderately	Slightly	Not
11. Having a baby who takes away from how much I can give my other child(ren).	Very	Moderately	Slightly	Not
12. Taking care of a baby who is disagreeable and irritating.	Very	Moderately	Slightly	Not
13. Having a child who is a burden to my husband or mate.	Very	Moderately	Slightly	Not
14. Having a baby who is born deformed.	Very	Moderately	Slightly	Not
15. Worrying whether I am raising my child the right way.	Very	Moderately	Slightly	Not
16. Having a child who embarrasses or disgraces the rest of the family.	Very	Moderately	Slightly	Not
17. Taking care of a sick child.	Very	Moderately	Slightly	Not

Undesirable Consequences	How Undesirable			
18. Having a child who makes it necessary for me to have a job.	Very	Moderately	Slightly	Not
19. Feeling guilty or inadequate as a parent.	Very	Moderately	Slightly	Not
20. Experiencing the pain of childbirth.	Very	Moderately	Slightly	Not
21. Having a baby who takes away my freedom to do other things.	Very	Moderately	Slightly	Not

PREGNANCY RESOLUTION Code Number_____

This section deals with the actual decision(s) to have an abortion(s). It refers to the time period from the moment a woman begins to actively consider abortion to the final confirmation that abortion is the solution to the pregnancy/pregnancies. **Remember, we are referring to only those pregnancies that resulted in a first trimester abortion.**

ADQII

We are interested in your reasons or motivations for making the decision(s) to have an abortion(s). Think back to when you made the decision(s) and **try to recall what your reasons or motivations were**. Then read over the list of reasons for and against the decision(s) which are listed below. Finally, circle the word to the right of each reason which best indicates how important that reason was to you at the time you made the decision(s).

A. **Reasons for having an abortion**:	**How Important**			
1. Having a baby then would have prevented me from working/going to school.	Very	Moderately	Slightly	Not
2. I (we) could not afford a baby.	Very	Moderately	Slightly	Not
3. Problems with my boyfriend (marital problems) made it a bad time to have a baby.	Very	Moderately	Slightly	Not
4. I was not emotionally ready to take on the responsibility of a baby then.	Very	Moderately	Slightly	Not
5. My boyfriend (husband) was not ready for a baby then.	Very	Moderately	Slightly	Not
6. Our life together (our family life) was already satisfactory the way it was.	Very	Moderately	Slightly	Not
7. I was very busy with other interests outside the home.	Very	Moderately	Slightly	Not

A. **Reasons for having an abortion**:	**How Important**			
8. I was worried about the risks of pregnancy and/or child birth.	Very	Moderately	Slightly	Not
9. Having a small baby which would depend so much on me was an upsetting possibility.	Very	Moderately	Slightly	Not
10. I wanted more time with my boyfriend (husband) before having a baby (adding to the family).	Very	Moderately	Slightly	Not
11. I felt I was getting too old.	Very	Moderately	Slightly	Not
12. I was not married.	Very	Moderately	Slightly	Not

B. **Reasons against having an abortion**	**How Important**			
13. We both were ready for a baby then anyway.	Very	Moderately	Slightly	Not
14. Part of me felt it was wrong to have an abortion.	Very	Moderately	Slightly	Not
15. I enjoyed being pregnant.	Very	Moderately	Slightly	Not
16. My family and/or friends disapproved of abortion.	Very	Moderately	Slightly	Not
17. I wanted to have a baby to take care of and love.	Very	Moderately	Slightly	Not
18. My boyfriend (husband) was opposed to abortion.	Very	Moderately	Slightly	Not
19. I was worried about not being able to get pregnant again.	Very	Moderately	Slightly	Not
20. It seemed hard to take a life into my own hands.	Very	Moderately	Slightly	Not

B. **Reasons against having an abortion**	**How Important**			
21. My boyfriend (husband) wanted a baby.	Very	Moderately	Slightly	Not
22. I was worried an abortion would upset me afterwards.	Very	Moderately	Slightly	Not
23. My religion did not allow abortion.	Very	Moderately	Slightly	Not

We are interested in **how** you made your decision(s) about having your abortion(s), how you considered different possibilities and how you arrived at your choice.

24. When you were making your decision(s) to have the abortion(s) how important was it for you to get another person's opinion about whether or not to have an abortion. Place the number which best describes your experience next to the specific procedure: 1) if it was very important; 2) if it was somewhat important 3) it was neither important or unimportant; 4) if it was unimportant

1st procedure_____	6th procedure_____
2nd procedure_____	7th procedure_____
3rd procedure_____	8th procedure_____
4th procedure_____	9th procedure_____
5th procedure_____	10th procedure_____

25. With whom did you discuss having an abortion(s) before making your decision? [List everyone according to their relationship, e.g., boyfriend (husband), father, mother-in-law, friend, physician, etc. List only the four most important people i there were more than four. List them in order of importance.

1) _____	3) _____
2) _____	4) _____

26. What were the attitudes of the following four groups towards your having the abortion(s)? Fill in the blank spaces with the number which best indicates their attitude. If any of the four groups do not fit your situation, leave that blank space empty.

    1) For
    2) Mixed; For and Against
    3) Against
    4) Neutral
    0) Attitude Unknown

    a) Own family _____
    b) Own personal friends _____
    c) Boyfriend's (husband's) family _____
    d) Boyfriend's (husband's) personal friend's _____

27. Was there anyone that helped you to make the decision(s) to have the abortion(s). More than likely, this is the person with whom you discussed your abortion(s) decision(s). Write down the type of relationship you had with the main person who helped you make the decision to have the abortion(s), for example, mother, girlfriend, boyfriend, husband, etc.,)

    1st procedure_____ 6th procedure_____
    2nd procedure_____ 7th procedure_____
    3rd procedure_____ 8th procedure_____
    4th procedure_____ 9th procedure_____
    5th procedure_____ 10th procedure_____

28. Was there any conflict or disagreement between you and your boyfriend (husband) while making the decision(s)?

    1. Yes, a lot
    2. Yes, some
    3. No

29. Was one of you more motivated to having the abortion(s) than the other? (Check one)

    1. Yes, me
    2. Yes, my boyfriend (husband)
    3. No

30. Was there any particular event which played a big role in making your decision(s)?

1. Yes
2. No

30a. If yes, what_____

_____

_____

_____

_____

_____

_____

_____

32. Once you had made your decision(s), how certain about it were you in your own mind?

1. Very certain
2. Mostly certain
3. Some doubt
4. Considerable doubt

For the following questions, if the question doesn't apply to you [for instance, if your partner or family or friends didn't know about your pregnancy/pregnancies or abortion decision(s)], please circle not applicable and continue on with the next question.

33. To what extent do you feel your partner(s) supported your decision(s) to have the abortion(s)?

doesn't support me at all 1 2 3 4 5 6 7 totally supports me

not applicable

34. To what extent do you feel your family supported your decision(s) to have the abortion(s)?

doesn't support me at all 1 2 3 4 5 6 7 totally supports me

not applicable

35. To what extent do you feel your friends supported your decision(s) to have the abortion(s)?

doesn't support me at all	1	2	3	4	5	6	7 totally supports me

not applicable

RAQ

The following statements are about prominent social issues. Please read each sentence carefully and indicate whether you "Strongly Disagree," "Disagree," "Agree," or "Strongly Agree" with each one, or whether you have "Mixed Feelings" about the statement. Remember, there are no right or wrong answers. Please don't skip any items.

I. Views about Abortion

	Strongly Disagree	Disagree	Mixed Feelings	Agree	Strongly Agree
1. Abortion is a matter of personal choice.	1	2	3	4	5
2. Abortion is a threat to our society.	1	2	3	4	5
3. A woman should have control over what is happening to her own body by having the option to choose abortion.	1	2	3	4	5
4. Only God, not people can decide if a fetus should live.	1	2	3	4	5
5. Even if one believes that there may be some exceptions, abortion is still basically wrong.	1	2	3	4	5

	Strongly Disagree	Disagree	Mixed Feelings	Agree	Strongly Agree
6. Abortion violates an unborn person's fundamental right to life.	1	2	3	4	5
7. A woman should be able to exercise her rights to self-determination by choosing to have an abortion.	1	2	3	4	5
8. Outlawing abortion could take away a woman's sense of self and personal autonomy.	1	2	3	4	5
9. Outlawing abortion violates a woman's civil rights.	1	2	3	4	5
10. Abortion is morally unacceptable and unjustified.	1	2	3	4	5
11. In my reasoning, the notion that an unborn fetus may be a human life is not a deciding issue in considering abortion.	1	2	3	4	5
12. Abortion can be described as taking a life unjustly.	1	2	3	4	5
13. A woman should have the right to decide to have an abortion based on her own life circumstances.	1	2	3	4	5

	Strongly Disagree	Disagree	Mixed Feelings	Agree	Strongly Agree
14. If a woman feels that having a child might ruin her life, she should consider abortion.	1	2	3	4	5
15. Abortion could destroy the sanctity of motherhood.	1	2	3	4	5
16. An unborn fetus is a viable human being with rights.	1	2	3	4	5
17. If a woman feels she can't care for a baby, she should be able to have an abortion.	1	2	3	4	5
18. Abortion is the destruction of one life for the convenience of another.	1	2	3	4	5
19. Abortion is the same as murder.	1	2	3	4	5
20. Even if one believes that abortion is wrong, it is still a woman's right to choose whether or not to have one.	1	2	3	4	5

IIS
FEMALE FORM

This is not a test. There are no right or wrong responses to any of the following items. Just answer each one as honestly as you can based on the amount of influence your partner has had or will have on the following decisions with which you have been faced or will probably be faced. In other words, indicate the amount of influence you feel your partner has had or will have on the outcome of each of the decisions listed below.

In this survey a "partner" is someone of the opposite sex who is important to you, such as a spouse, fiance, boyfriend or intimate friend, and in whose life you play an important role.

Please work carefully and quickly. Do not spend a long time on any one item. Please respond to each item and circle only one response to each. Indicate your answer by circling one of the five responses given beside each statement, where:

1=NO INFLUENCE 2=LITTLE INFLUENCE 3=FAIR AMOUNT OF INFLUENCE

4=MUCH INFLUENCE 5=VERY MUCH INFLUENCE

EXAMPLE:

0. Initiating social activities with mutual friends . . . 1 2 3 4 5

In the sample item, a **2** has been circled. This means that the male partner has little influence in initiating social activities with the couple's mutual friends.

---

1. Determining the distance we will live from either set of parents . 1 2 3 4 5
2. My decision to change occupations 1 2 3 4 5
3. Deciding on the type of community activities in which I will participate 1 2 3 4 5
4. Determining who my friends are 1 2 3 4 5
5. Deciding on the type of community activities in which we will participate 1 2 3 4 5
6. Deciding who we will have as friends 1 2 3 4 5
7. Deciding on our amount of involvement in religious activities . . . 1 2 3 4 5
8. My acceptance of a promotion in my occupation 1 2 3 4 5
9. My changing jobs within the same occupation 1 2 3 4 5
10. Determining what types of activities in which we will engage with mutual friends 1 2 3 4 5

1=NO INFLUENCE 2=LITTLE INFLUENCE 3=FAIR AMOUNT OF INFLUENCE

4=MUCH INFLUENCE 5=VERY MUCH INFLUENCE

11. Determining the allocation of monetary family and personal resources for civic activities 1 2 3 4 5

12. Deciding to marry or to live together on a permanent basis 1 2 3 4 5

13. My attendance or nonattendance of religious services 1 2 3 4 5

14. Determining our family goals 1 2 3 4 5

15. My working for advancement in my occupation 1 2 3 4 5

16. Deciding what religion, if any, to which we will belong 1 2 3 4 5

17. Finding a balance between my personal goals and our goals as a family 1 2 3 4 5

18. Deciding how much energy I will expend on leisure activities . . . 1 2 3 4 5

19. Determining the type of community in which we will live 1 2 3 4 5

20. My decision to work or not to work outside our home for pay . . 1 2 3 4 5

21. Deciding on the amount of involvement I will have in organized religion 1 2 3 4 5

22. My selection of a new hobby or recreational interest 1 2 3 4 5

23. My decision to be active or nonactive in civic activities 1 2 3 4 5

24. My acceptance of a particular job 1 2 3 4 5

25. Our allocation of non-monetary family or personal resources for politics 1 2 3 4 5

26. Deciding on the amount of my political involvement 1 2 3 4 5

27. Determining who will take care of our children 1 2 3 4 5

28. Setting my personal goals 1 2 3 4 5

1=NO INFLUENCE 2=LITTLE INFLUENCE 3= FAIR AMOUNT OF INFLUENCE

4=MUCH INFLUENCE 5=VERY MUCH INFLUENCE

29. My establishment of independence from my parents 1 2 3 4 5

30. Deciding how much family resources to expend on leisure that both of us enjoy 1 2 3 4 5

31. Our allocation of monetary personal and family resources for religious activities 1 2 3 4 5

32. Deciding to rent or purchase a residence 1 2 3 4 5

33. My decision to drop one recreational interest for another 1 2 3 4 5

34. Determining the type of religious activity in which I will participate 1 2 3 4 5

35. Deciding on the type of religious activity in which we will become involved 1 2 3 4 5

36. Deciding on the type of political activity in which we will engage 1 2 3 4 5

37. Determining what to do when my goals and his goals conflict . . . 1 2 3 4 5

38. Deciding to live in single or multiple family housing 1 2 3 4 5

39. Deciding how to spend leisure time as a couple 1 2 3 4 5

40. My decision to participate or not to participate in political activities 1 2 3 4 5

41. My decision to give up my personal goals 1 2 3 4 5

42. Determining the allocation of monetary personal and family resources for political activities 1 2 3 4 5

43. Choosing, as a couple, to have friends or not to have friends 1 2 3 4 5

44. Deciding which, if any, community activities we will join 1 2 3 4 5

1=NO INFLUENCE 2=LITTLE INFLUENCE 3= FAIR AMOUNT OF INFLUENCE

4=MUCH INFLUENCE 5=VERY MUCH INFLUENCE

45. Allocation of non-monetary personal and family resources for civic events 1 2 3 4 5

46. Determining how to meet the interests and needs of both him and me within our relationship 1 2 3 4 5

47. Determining the geographical location where we will live 1 2 3 4 5

48. Deciding to change our family goals 1 2 3 4 5

49. Determining how to spend family income 1 2 3 4 5

50. Deciding to have or not to have children 1 2 3 4 5

51. Determining how close I will be with my personal friends 1 2 3 4 5

52. Determining whose goals receive family resources when my goals and his goals conflict and there are not enough resources to satisfy both 1 2 3 4 5

53. Determining how much time we spend with mutual friends 1 2 3 4 5

54. Determining the type of neighborhood in which we will live 1 2 3 4 5

55. Allocating personal and family resources necessary to attain personal goals 1 2 3 4 5

56. Determining the appropriate expression of sexuality in our relationship 1 2 3 4 5

57. Deciding how I spend my individual leisure time 1 2 3 4 5

58. My decision on which, if any, political party to join 1 2 3 4 5

59. Our allocation of non-monetary personal and family resources for religious activities 1 2 3 4 5

60. Determining the way our children will be raised 1 2 3 4 5

POST ABORTION RESPONSE Code Number_____

This section of the survey asks questions about the different feelings and events that may have occurred after the abortion(s).

PPQ

The purpose of this questionnaire is to collect factual information about your abortion(s) experience. We believe an understanding of the feelings and problems that you might have experienced can be used to help others who are in the same situation. The information you give us will be kept strictly confidential and your name will not be used in any way.

1. All in all, are you satisfied with your decision(s) to have an abortion(s)?

   1. Yes 2. No

2. If a friend were considering an abortion, would you encourage her?

   1. Yes 2. No.

3. Have you noticed any major changes in your relationship with family members since your abortion(s)?

   1. Yes 2. No.

   3a. If yes, explain _____
   _____
   _____
   _____

4. Have you noticed changes in your relationships with friends since your abortion(s)?

   1. Yes 2. No.

   4a. If yes, explain _____
   _____
   _____
   _____

5. Have you noticed any change in your relationship with your partner(s) since your abortion(s)?

1. Yes 2. No.

5a. If yes, explain _____

_____

_____

_____

6. Have you been sexually active since your abortion(s)?

1. Yes 2. No.

The following are some words and phrases that describe various kinds of reactions that a woman may experience after an abortion. **Please consider each of these by thinking back to the time of your abortion(s) and try to tell me whether or not you experienced any of these reactions.** We would like you also to consider each reaction in terms of the present.

Try to rate yourself on these reactions by circling a number along each sliding scale that most nearly corresponds to the intensity of your feelings as you remember them to have been at the time of your abortion(s) and as you feel now.

1. **SADNESS**

At the time of the abortion(s)

1 2 3 4 5 6 7 8 9

No Moderate Very
Sadness Sad

Now

1 2 3 4 5 6 7 8 9

No Moderate Very
Sadness Sad

2. **LOSS OF APPETITE**

At the time of the abortion(s)

1 2 3 4 5 6 7 8 9

No Moderate Severe
Loss Loss

Now

1 2 3 4 5 6 7 8 9

No Moderate Severe
Loss Loss

3. **IRRITABILITY**

At the time of the abortion(s) *Now*

1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
None Moderate Much None Moderate Much

4. **SLEEPING PROBLEMS**

At the time of the abortion(s) *Now*

1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
No Problem Moderate Problems Severe Problems No Problem Moderate Problems Severe Problems

5. **DIFFICULTY CONCENTRATING**

At the time of the abortion(s) *Now*

1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
No Difficulty Moderate Difficulty Great Difficulty No Difficulty Moderate Difficulty Great Difficulty

6. **PREOCCUPATION WITH THOUGHTS ABOUT THE ABORTION**

At the time of the abortion(s) *Now*

1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
No Thoughts Moderate Thoughts Many Thoughts No Thoughts Moderate Thoughts Many Thoughts

7. **DEPRESSION**

At the time of the abortion(s) *Now*

1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
None Moderate Severe None Moderate Severe

8. **ANGER**

At the time of the abortion(s) *Now*

1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
No Anger			Moderate				Severe Anger		No Anger			Moderate				Severe Anger	

9. **GUILT**

At the time of the abortion(s) *Now*

1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
No Guilt			Moderate				Severe Guilt		No Guilt			Moderate				Severe Guilt	

10. **PROBLEMS RETURNING TO USUAL ACTIVITY**

At the time of the abortion(s) *Now*

1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
No Problem			Moderate				Severe Problem		No Problem			Moderate				Severe Problem	

11. **REPETITIVE DREAMS ABOUT THE ABORTION**

At the time of the abortion(s) *Now*

1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
No Dreams			Moderate				Many Dreams		No Dreams			Moderate				Many Dreams	

12. **EXHAUSTION**

At the time of the abortion(s) *Now*

1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
No Exhaustion			Moderate				Severe Exhaustion		No Exhaustion			Moderate				Severe Exhaustion	

13. **LACK OF STRENGTH**

At the time of the abortion(s)	*Now*
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
No Problem Moderate Lack Severe Lack	No Problem Moderate Lack Severe Lack

PSES

Here are some other kinds of questions. Now we would like you to think back about how you felt soon after your abortion(s). There are a number of situations that may come up after your abortion(s). Some tasks you may have found easy to do and some you may have found difficult. Below are a number of things that you might have had to do after your abortion(s). For each one, please circle the number that indicates how well you did that task after your abortion(s).

For example:

0 = you couldn't do the task at all.
1 = you thought you could do it, but it was just about impossible.
5 = you did it moderately well.
10 = you definitely did it

1. Carry on your normal school/work activities?

0 1 2 3 4 5 6 7 8 9 10
couldn't do it at all — definitely did it

2. Thought about children/babies comfortably (not be upset or think about them too much or avoid thinking about them)?

0 1 2 3 4 5 6 7 8 9 10
couldn't do it at all — definitely did it

3. Thought about future pregnancy/pregnancies comfortably (not be upset or overly-worried about it or not think about it at all)?

0 1 2 3 4 5 6 7 8 9 10
couldn't do it at all — definitely did it

For example: 0 = you couldn't do the task at all.
1 = you thought you could do it, but it was just about impossible.
5 = you did it moderately well.
10 = you definitely did it

4. Kept up a good relationship(s) with your boyfriend(s)/husband(s)?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

5. Spend time around children/babies comfortably (not be upset or spend too much time or avoid them)?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

6. Drive past facility where you had the abortion(s), or come into the building?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

7. Continued to have good sexual relations?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

8. Watched TV shows or read newspaper/magazine stories about abortion(s)?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

9. Have a comfortable day on the anniversary/anniversaries of your abortion(s)?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

For example: 0 = you couldn't do the task at all.
1 = you thought you could do it, but it was just about impossible.
5 = you did it moderately well.
10 = you definitely did it

10. Talk to your friends about your abortion(s)?

0	1	2	3	4	5	6	7	8	9	10
couldn't do it at all										definitely did it

11. How well do you think you coped with the abortion(s)?

not well at all 1 2 3 4 5 6 7 extremely well

12. How would you describe your relationship(s) with the conceptor(s) since your abortion(s)?

1. Good
2. Fair
3. Poor
4. Very Poor

3. Sometimes, having an abortion(s) can cause changes in a relationship. Has your abortion(s) led to any problems in the relationship(s) with the man/men who got you pregnant?

1. There were no changes in our relationship(s)
2. We were a little less close since my abortion(s)
3. We are definitely less close since my abortion(s)
4. We have had serious problems or a break in our relationship(s) since my abortion(s)
5. We are a little more close since my abortion(s)
6. We are definitely more close since my abortion(s)
7. My relationship(s) with the man/men who got me pregnant changed for the better since my abortion(s)

14. Sometimes an abortion will interfere with a couple's normal relationship and cause arguments or problems between them. Have you and the man who got you pregnant had any arguments, if so to what degree?

1. No arguments
2. Some arguments
3. Frequent arguments
4. Constant arguments

For the following questions, if the question doesn't apply to you [for instance, if your partner or family or firends didn't know about your pregnancy/pregnancies or abortion(s)], please circle "not applicable" and continue on with the next question.

15. How much did you feel you could depend on your partner(s) for social support during the few months after the abortion(s)?

can't depend on him at all for support 1 2 3 4 5 6 7 can depend on him totally for support

not applicable

16. How much did you feel you could depend on your family for social support during the few months after the abortion(s)?

can't depend on them at all for support 1 2 3 4 5 6 7 can depend on them totally for support

not applicable

17. How much did you feel you could depend on your friends for social support during the few months after the abortion(s)?

can't depend on them at all for support 1 2 3 4 5 6 7 can depend on them totally for support

not applicable

18. For each abortion that you have had, please write down how emotionally intense the entire experience was for you (from the moment you knew that you were pregnant to after the abortion). Was the experience, place the number next to the specific procedure.

1. Mild 2. Moderate 3. Severe

1st procedure_____ 6th procedure_____
2nd procedure_____ 7th procedure_____
3rd procedure_____ 8th procedure_____
4th procedure_____ 9th procedure_____
5th procedure_____ 10th procedure_____

19. How did you feel during the first week or two after the abortion(s)?

1. Relief
2. Relief mixed with distress
3. Mostly distress

20. Did you have any significant emotional upset or disturbance after the first few weeks since the abortion(s)?

1. No
2. Yes, little
3. Yes, some
4. Yes, much

20a. What was the upset?_____

_____

_____

_____

21. Looking back, do you have any regrets about the decision to have the abortion(s)?

    1. No
    2. Not sure
    3. Yes

    21a. If you do have any regrets, what are they?_____

_____

_____

_____

IES

Directions: Below is a list of comments made by people about stressful life events and the context surrounding them. Read each item and decide how frequently each item was true for you during the past seven (7) days, when you think about the abortion(s) that you have had. If the item did not occur during the past seven days, choose the NOT AT ALL option. Make a check mark on the line under the heading which best describes that item. Please complete each item.

	NOT AT ALL	RARELY	SOME-TIMES	OFTEN
1. I thought about it when I didn'tmean to.	____	____	____	____
2. I avoided letting myself get upset when I thought about it or was reminded of it.	____	____	____	____
3. I tried to remove it from memory.	____	____	____	____
4. I had trouble falling asleep or staying asleep, because of pictures or thoughts that came to my mind.	____	____	____	____
5. I had waves of strong feelings about it.	____	____	____	____

	NOT AT ALL	RARELY	SOME-TIMES	OFTEN
6. I had dreams about it.	____	____	____	____
7. I stayed away from reminders of it.	____	____	____	____
8. I felt as if it hadn't happened or wasn't real.	____	____	____	____
9. I tried not to talk about it.	____	____	____	____
10. Pictures about it popped into my mind.	____	____	____	____
11. Other things kept making me think about it.	____	____	____	____
12. I was aware that I still had a lot of feelings about it.	____	____	____	____
13. I tried not to think about it.	____	____	____	____
14. Any reminder brought back feelings about it.	____	____	____	____
15. My feelings about it were kind of numb.	____	____	____	____

EQ

Please circle the number that best represents how strongly you have felt each of these emotions listed below when you think about your abortion(s).

	not at all	to a small degree	to a moderate degree	to a considerable degree	extremely
anxious	1	2	3	4	5

	not at all	to a small degree	to a moderate degree	to a considerable degree	extremely
in control	1	2	3	4	5
embarrassed	1	2	3	4	5
proud	1	2	3	4	5
regretful	1	2	3	4	5
guilty	1	2	3	4	5
relieved 1	2	3	4	5	
ashamed	1	2	3	4	5
fearing disapproval	1	2	3	4	5
competent	1	2	3	4	5
angry	1	2	3	4	5
depressed	1	2	3	4	5
happy	1	2	3	4	5
doubtful	1	2	3	4	5
disappointed in self	1	2	3	4	5
scared	1	2	3	4	5

Consec____ Yrs Since_____ Age @ Last TP_____

ID_____ Age_____ Aborter_____

STANDARDIZED OPEN ENDED INTERVIEW

Hello, may I speak to_____. My name is Maria J. Rivera, I am a graduate student in clinical psychology. If you remember, you participated in a study last year, that asked women about their experience of abortion. At the end of the questionnaire, you signed a consent form agreeing to a confidential interview. I would like to make the interview as convenient as possible. Please remember that the entire interview is confidential.

How would you like to conduct the interview: on the phone or in person?

Person: where would you like to do the interview (your home? school?)
When would you like to do the interview?

Phone: When would be the best time to call you, and do the interview?

At the actual interview:

The purpose of this interview is to get a better understanding of how women experience abortion. Maybe you can tell me things that were not on the questionnaire. Please answer all questions to the best of your ability. Remember that everything you say is confidential, and you may stop the interview at any time or refuse to answer any questions. Thank you for your participation.

Pregnancy Context

1. Do you remember how you felt when you first found out you were pregnant? What was your initial reaction to being pregnant? (**Probe:** positive, negative, confused)

2. Although you may not have planned (intended) to get pregnant, was there any point during the pregnancy that you may have wanted the pregnancy(s)?

3. Did you ever perceive or think about a baby while you were pregnant?

4. What kind of relationship did you have with the man/men who got you pregnant? Was there any connection between how you felt about the pregnancy and the type of relationship you had with the man/men who got you pregnant?

Decision Context

5. While deciding to have your abortion(s) was there anything that made you feel certain about having the procedure(s)?

6. Was there anything that made you feel ambivalent (doubtful) about the procedure? Did this create any conflict in making the decision?

7. Was there anything that could have changed your mind about having the procedure, i.e. continue the pregnancy?

8. What did the man/men who got you pregnant think about you having the abortion/s? Was there anything about the man(men) who got you pregnant that affected your decision. How much influence did he have in your decision? How did he/they affect your decision?

9. Once you made the decision to abort, did anything change in your relationship with the man/men who got you pregnant?

Post Abortion Response

10. How do you feel about the procedures? **(Probe: positive feelings, negative feelings)**

11. Do you feel that the abortion(s) may have changed you in a positive way, how?

    Have the abortions changed you in a negative way, how?

12a. Do you think about your abortion/s? How much?

12b. Are there any times when you think about your abortions more than you normally would? **(Probe: during the anniversary, around other children, when you pass the clinic)**

13. Have you learned anything from having the procedure(s)? Have you learned anything about yourself? Has anything changed about yourself?

14. How did you get along with the man/men who got you pregnant after you had the abortion(s)? How did he treat you?

Multiple Aborter Question Only

1. Is there any abortion procedure that you tend to think about more than the others? Why? **(Probe: e.g. more intense emotionally/physically).**

2. Does anyone know that you have had several procedures? Who? Why did you choose to tell that person? What was their reaction?

3. Is there any particular person that you prefer not to tell about the abortions? Who? Why do you choose not to tell that person?

4. Did having several procedures affect you in any way? (e.g. **positive: in control, more vigilant about birth control or do you see yourself as more of an adult due to abortions? Negative: Do you feel that you lost some sense of innocence? Do you feel guilty?)**

5. Do you feel that there is any reason that caused you to have several procedures?

Question for everyone

*****6. Is there anything important that I may have left out? Is there something you would like to add about your experience with the abortion/s?

APPENDIX B

PRESENTATION AND INSTRUCTIONS

Presentation

Ladies,

My name is Maria Rivera, I am a graduate student in Clinical Psychology, doing research in the area of women's reproduction. This study looks at women's reproductive choices, especially women's experience of abortion. **The questionnaire is designed to look at three time periods of the abortion experience; the moment a woman learns she is pregnant, the decision to abort, and how she feels after the procedure. Women who have taken the survey see it as an opportunity to discuss their abortions, with total confidentiality. Women don't often have a forum to discuss their abortions, and this survey is a place to do this, with total anonymity.**

I understand that many women are strongly opposed to abortion, and I respect your opinion. You do not have to fill out the questionnaire. In fact, many women who are against abortion are often forced to have an abortion due to life circumstances or contraceptive failure. **Your participation in this study is entirely voluntary. Whether you choose to participate or not, will not affect your grade in any way. Should you choose to participate in the study, your answers will be entirely confidential, no one, other than myself will see the questionnaire. You are asked to sign a consent form, but you may put an "X".**

Please complete this survey within the next couple of days. **Most women find it easier to do the survey in private. It will take you about one hour and 15 minutes in to complete it. What women find most difficult is that they may have to think back, since many women have had their abortions some time ago.** Try to answer all the questions to the best of your ability. If any questions arise while you take the survey, please call me at (212)551-2542, or (212)650-5442. For confidentiality, you can introduce yourself as a "survey participant." You may write your comments and questions on the margins of the survey.

Once you have finished the survey, place it in the envelope and seal it. Return the sealed survey to either your instructor, or the room that has been assigned as the "drop off room." In that room will be a large box which will say "Women's Reproduction Study," place the study in the box.

If you know that you do not want to do the survey <u>at this time,</u> you can return the survey to me, at the end of this presentation. PLEASE DO NOT MARK THE SURVEY IN ANY WAY. If you take the survey and then choose not to do it for whatever reason, you can return the unmarked survey in the envelope to the assigned "drop off room" .

***** **The assigned "drop off room" in your school is**_____

Any questions, or comments?

If you know any other women who may be interested in taking the survey please take more than one packet

I will now pass out the survey packet.

Instructions

Ladies,

Thank you for your participation in this study. Please complete this survey within the next couple of days. The survey is entirely confidential. Most women find it easier to do the survey in private. It will take you about one hour and 15 minutes in to complete it. Questions are on the front and back of the pages. If any questions or problems arise while you take the survey, please call me at (212)551-2542, or (212)650-5442. Or, you can write your comments and questions on the margins of the survey.

Once you have finished the survey, place it in the envelope and seal it. Return the sealed survey to the room that has been assigned as the "drop off room." This is listed below. In that room will be a cardboard box, which will say "Women's Reproduction Study," you may place the study in the box.

***** The room in your school is_____

APPENDIX C

CONSENT FORMS

Code Number_____

CONSENT FORM

Ladies:

I am a doctoral student in clinical psychology, doing research in the area of women's reproductive decisions and choices. This study is about women's experience of pregnancy and abortion. Your participation in the study is entirely voluntary. Should you choose to do the survey, your answers will be entirely confidential and no one will have access to the questionnaire other than myself. You can skip any question or stop the survey at any time. Your grades will not be affected in any way by your participation decision. If you have any questions please ask me.

If you have never had an abortion or do not want to participate in this survey, please hand in the consent forms and the questionnaire unsigned and unmarked. Do not mark the questionaire, and return it to the office assigned as the drop off room for the questionnaires.

If you decide to participate please sign below (you can sign your first name only). Thank you for your time, assistance and effort.

Respectfully,

Maria J. Rivera,
Doctoral Candidate

_____
(Name)

_____
(Date)

Code Number_____

CONSENT FORM II

Dear Participant:

Thank you very much for completing the questionnaire. In doing so, you have helped to develop a better understanding of what may occur. In order to get a more comprehensive understanding, it would be nice to interview you individually. I would like to extend an invitation to you for a private interview regarding your own personal experience. The interview will be at your convenience. I guarantee full confidentiality. Your name will not be associated with your responses in any way. You may stop the interview at any time, or refuse to answer any of the questions. Your decision will in no way affect your grades.

If you agree to an interview, please sign below (first name only, if you prefer), and leave a phone number so that I can call you to set up an appointment. If you prefer, upon handing in the questionnaire, you can arrange a time with me then. Again, I thank you for your time and effort.

Respectfully,

Maria J. Rivera,
Doctoral Candidate

I agree to a one to one interview, and understand that everything that I say will be completely confidential.

_____
Name (first name only if you prefer)

_____
Phone number (you can leave a time and/or date when it is best to call)

If you would like to find out the results of the study, or if you would like to ask me any questions, or if you have any concerns, please feel free to call me at the following numbers: (212) 650-5443 or (212) 551-2542. I would be happy to answer any questions you may have.

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