A PHENOMENOLOGICAL INVESTIGATION INTO THE EXPERIENCES OF TERMINATION OF PREGNANCY

BY

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Dedication

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ABSTRACT

The purpose of this research is to describe the experiences of females who have undergone a termination of pregnancy. A phenomenological study was employed, in which each participant used in the research was interviewed in a single session.

The sample consisted of six women who had terminated a pregnancy before. The results were presented in the form of an integrative text, which accounted for all the individual variations of the experiences of termination. The ages of women ranged from 17 to 42. All participants regarded the situation of an unplanned pregnancy as stressful. Most of them viewed having a child as a threat to their education, career or relationship with family. Although all of the participants thought some part of the procedure was more stressful than they anticipated, they all found ways to cope with differing levels of stress. All participants view themselves as coping well with the stressful life event.
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Table of contents

<table>
<thead>
<tr>
<th>Abstract</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

CHAPTER 1

1.1 Introduction 1
1.2 Statement of the problem 1
1.3 Motivation of the study 2
1.4 Aim of the study 2
1.5 Objectives of the study 2
1.6 Conceptual framework 3
1.7 Methodology 3
1.7.1 Sampling 3
1.8 Research technique 4
1.9 Value of research 4

CHAPTER 2

Literature review

2.1 South African termination of pregnancy background 5
2.2 What is therapeutic termination of pregnancy? 9
2.3 Termination of pregnancy statistics in South Africa 11
2.4 Types of termination of pregnancy procedures 11
2.5 Conditions in which pregnancy may be terminated 14
2.6 Post-termination of pregnancy trauma 14
2.7 Termination of pregnancy counseling 16
2.8 Emotional legacy of termination of pregnancy 21
2.9 The Natural Law Ethical Theory 22
2.10 The Principle of Double Effect 27
2.11 Feminist view on termination of pregnancy 31
2.12 Conclusion 32

CHAPTER 3

Methods and procedures of the investigation
3.1 Procedure 33
3.2 Interview 33
3.3 Participant selection 34
3.4 Confidentiality 35
3.5 Participants 35

CHAPTER 4

Findings and discussion of the study
4.1 Participants experiences 36-50
4.2 Discussion of the findings 50-57

CHAPTER 5

Conclusion and recommendations
5.1 Implications of the study 59
5.2 Limitations 60
5.3 Future research 62
5.4 Conclusion 62
CHAPTER 1

Introduction and motivation

Introduction
Termination of pregnancy (TOP) is still the procedure that most people frown upon. In general, the phrase refers to the termination of pregnancy before the fetus has attained viability, that is, before it has become capable of independent extra-uterine life (World Health Organization, 1997). According to Brien & Fairbain (1996) termination of pregnancy is a deeply emotive subject and has been at the center of many heartfelt campaigns, like those based on the belief that women should have absolute control over their own bodies.

Brien and Fairbain observed that the deliberate ending of pregnancy continues to be a source of social discord, moral uncertainty, medical and psychiatric confusion and personal anguish. Opponents of TOP argue on moral and religious grounds. They further note that the fair position in these arguments is that women must come to their own decision armed with all the relevant facts, and that they are entitled to help on the same basis as in any other situation where they seek medical help that is freely available from the health services.

Statement of the problem
As a means of fertility regulation, TOP is as old as humanity and probably occurs in all cultures. Throughout recorded history, women have resorted to TOP to terminate unwanted pregnancies, regardless of moral or legal sanctions and often at considerable physical or psychological risks and costs (David, 1974). The intension of the researcher is firstly to ascertain the impact of counseling before a termination of pregnancy. Secondly, to gain information as to what happens to the women who do not receive such counseling? The researcher assumes that those who do not receive such counseling would find it difficult to cope compared to those who get proper counseling before and after termination of pregnancy.
Motivation of the study
Since the introduction of TOP, many people, especially Christians, are concerned about the moral state of our nation. Although many are speaking out in favour of TOP, there are just as many organizations, religious groups and individuals who are against it. Pro-termination of pregnancy organizations lean heavily on rights of women to choose, to plan the amount of children they wish to have, their right to birth control and their right to respect and bodily integrity. Organizations like Lovelife and Reproductive Right Alliance are making their voices heard very loudly through the media. Likewise organizations like Doctors for Life and the African Christian Democratic Alliance are speaking out very strongly in opposition to TOP.

The large organizations have been vocal in stating what they believe in. Sadly one hardly hears a woman who has had a termination of pregnancy relating her experiences on this phenomenon. This has prompted the researcher to give such women a platform to share their experiences, their needs and the strategies they have used to cope with this experience.

Aim of the study
The aim of the study is to explore the role of counseling before and after termination of pregnancy; to explicate the experiences and needs of women who undergo TOP in a non-judgmental way, relatively undistorted through interpretation. This should provide a baseline for planned intervention with this target population.

Objectives of the study
The objective of the study is to find out whether women who undergo TOP experience emotional trauma, receive sufficient one on one termination of pregnancy counseling and also the mechanisms used in the past and present when faced with major stressors in their lives.
Conceptual framework and methodology

As an explication of the specific needs and experiences of persons undergoing TOP in a general hospital, the proposed research demands a qualitative and exploratory approach. This will grant the study community the space to express their needs as they experience them and more importantly, allow them to convey their conceptualization of the issues at stake as well as their agenda for how their needs can be met. The current psychological research emphasizes the importance of generating the knowledge on which community intervention is based in the specific study community (Dockecki, 1992).

Following Polkinghorne's (1989) general format for phenomenological research, the study will gather a number of naïve descriptions through unstructured interviews with persons who are experiencing the phenomena under investigation. This will entail asking a sample of the target group the research question individually, which would be unfocused and highly projective (the question should mean whatever the respondent wishes to make it mean, which in turn is the significant aspect of their needs and experiences the research aims to extract); engage in a process of analyzing these descriptions so that the researcher comes to grips with the common elements that make the experience of their needs and problems what it is. Finally produce a research report that gives a clear, accurate and articulate description of their needs, problems and experiences. The reader of the report should get a feeling that "I understand better what it is like to undergo a TOP procedure."

Methodology: Sampling

Selection criterion: Subjects who are pre-eminently suitable for phenomenological research would be those who have had direct experience of the phenomenon to be researched, can articulate and communicate their thoughts, feelings, and perceptions regarding the researched phenomenon. It will be imperative that they express willingness to be open with the researcher, and are naïve about theories regarding the research phenomenon. Their being untrained increases the probability of their verbalizing the data of their original experiences of the phenomenon. This
prevents undue interference from implicit philosophies of various schools of thought (Giorgi, 1985).

Research technique
The researcher has opted to follow the phenomenological method of research. This method requires that we first identify the phenomenon (in this case, the experiences of women with reference to TOP), select the interviewees (phenomenological research only demands as selection criteria that the respondents should have experienced the researched phenomenon and be willing to articulate their experience fluently and clearly. The sample will be extended to provide coverage for idiosyncratic differences that may exist among members of the target group). In this method it is also important that we get first person description (interview and protocol). The research will then read the description (protocol) and break each protocol down into Natural Meaning Units (NMU's).

The research will then formulate the situated structure for each respondent and enter into a discussion relating the current experiences and needs identified to current ways in which the needs of persons who undergo TOP are being addressed; before reflecting on the entire research procedure. The researcher will then conclude by writing a detailed research report (an overview, evaluation and recommendations).

Value of Research
The study undertaken will raise awareness of women on different options before they undergo TOP, provide informed recommendations on the nature of care and counseling to be provided for women who undergo TOP, enhance empathetic understanding of all health professionals working with these women. This will be done by providing an unbiased description of the women's experiences when faced with this issue in its entire spiritual and psychological dimensions.
CHAPTER 2

Literature review

As a means of fertility regulation, termination of pregnancy is as old as humanity and probably occurs in all cultures. Throughout recorded history women have resorted to termination of pregnancy to terminate unwanted pregnancy regardless of moral or legal sanctions and often at considerable physical or psychological risk and cost (David, 1974). Similarly to other medical practices, it has been regulated to prevent undue harm to patients. But unlike other medical procedures, limitations have also been implemented due to moral, religious and political concerns (Adler, 1979).

South African termination of pregnancy background

Up to 1975, the termination of pregnancy law in South Africa was governed by Roman-Dutch common law, which permitted termination of pregnancy only when the life of the mother would be endangered by continuation of the pregnancy. In practice, however, physicians often performed termination of pregnancy on other grounds without prosecution by law enforcement agencies. In 1968, for example, it was estimated that at least 28 per cent of terminations of pregnancy were performed for reasons other than saving the life of the mother (Reproductive Rights Alliance: 2002).

In 1975, The Termination of Pregnancy and Sterilization Act of 1975 (Act No. 2 of 1975) was enacted, which extended the grounds under which termination of pregnancy could be legally obtained in South Africa. Under the Act, as amended in 1982, termination of pregnancy could be performed in the following cases: (a) when the continued pregnancy endangered the woman’s life; (b) when the continued pregnancy constituted a serious threat to the woman’s physical or mental health; (c) when there was a serious risk that the child to be born would suffer from a physical or mental defect of such a nature as to be irreparably seriously handicapped; and (d) when the pregnancy was the result of unlawful...
intercourse such as rape or incest, or with an "idiot or imbecile". The termination of pregnancy had to be approved by three physicians and performed in a State-designated institution and was subject to other procedural requirements, depending on the indication. For example, when termination of pregnancy was requested because the pregnancy resulted from unlawful intercourse, the magistrate in whose district the offence was alleged to have occurred was required to provide the hospital superintendent with a certificate attesting to the fact that the alleged offence was reported to the police, or if no complaint was lodged, that there was a good and acceptable reason for it.

Although the Act in theory legalized termination of pregnancy under a broad series of indications, in effect, very few legal TOP's were performed after its enactment. Estimates are that fewer than 1,000 legal TOP's were carried out each year. Most TOPs', estimated to be at least 200,000 a year, were performed illegally. Some 45,000 of these resulted in hospitalisation due to incomplete termination of pregnancy and led to 1,500 to 3,000 deaths per year. In addition, the vast majority of these were performed on white women, who make up only a small percentage of the population seeking TOPs. The preponderance of white women among the women who obtained legal TOPs was evidently due to the strict procedural requirements imposed by the 1975 Act. These worked to the advantage of those with money, skill in dealing with government bureaucracy, and access to urban medical facilities.

This legal situation was dramatically altered in 1994 after the transition from the apartheid regime to full democracy and the victory of the African National Congress (ANC) in the first fully democratic elections in South Africa. The ANC had campaigned on a platform of liberalized termination of pregnancy and, once it came to power, it proceeded to fulfil its campaign pledge on this issue. After receiving the report of the Ad Hoc Select Committee on termination of pregnancy and sterilisation, appointed to review this matter, the Government introduced draft legislation in Parliament to allow TOPs to be performed on request during the first fourteen weeks of pregnancy. The proposed legislation provoked a heated debate between pro-choice and pro-life groups, and the latter held numerous rallies to protest suggested changes. Despite polls indicating that the
The great majority of the population did not support the legislation and considerable opposition among legislators both within and without the ruling ANC party, the legislation (the Choice on termination of pregnancy Act) was enacted in 1996, with almost one quarter of the legislators absent.

The new Act on Choice of Termination of Pregnancy (Act No.92 of 1996) determines circumstances in which, and conditions under which, the pregnancy may be terminated and provides for matters connected therewith. In its preamble the Act recognizes the value of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism and the advancement of human rights and freedom which underlie a democratic South Africa. This Act recognizes that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies. It also recognizes that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth. Furthermore, the Act recognizes that the decision to have children is fundamental to women’s physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counseling programmes and services. The Choice of Termination of Pregnancy Act promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

Termination of pregnancy is based on a time-frame model. During the first twelve weeks of pregnancy, a woman may obtain termination of pregnancy upon request. From the thirteenth to the twentieth week of pregnancy, termination of pregnancy may be performed in the following circumstances: if a medical practitioner is of the opinion that the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; if there is a substantial risk that the fetus would suffer from a severe physical or mental abnormality; if the pregnancy resulted from rape or incest; or if the continued pregnancy would
significantly affect the social or economic circumstances of the woman. After the twentieth week of pregnancy, termination of pregnancy may be performed if two medical practitioners or one medical practitioner and a midwife are of the opinion that the continued pregnancy would endanger the woman's life, or would result in severe malformation of the fetus or would pose a risk of injury to the fetus.

Although all TOPs must be performed in government-designated facilities, during the first twelve weeks, termination of pregnancy may be performed by a medical practitioner or a midwife; after this period only a medical practitioner is qualified to carry out termination of pregnancy. While non-directive and non-mandatory counseling is encouraged, it is in no case mandated, and all women requesting termination of pregnancy are to be informed of their rights under the Act. As long as the woman is mentally competent, no parental or spousal consent is required, even in the case of a minor. If the woman is mentally incompetent or in a state of continuous unconsciousness, termination of pregnancy may be carried out with the consent of her guardian or spouse and the fulfilment of various other procedural requirements. The Act contains detailed notification and record keeping requirements and imposes penalties of a fine or up to ten years' imprisonment on those who perform TOPs in contravention of its provisions or who prevent the lawful termination of a pregnancy or obstruct access to a facility for the termination of pregnancy.

The 1996 Termination of Pregnancy Act is now the most liberal Act authorizing the performance of TOPs, not only during the first trimester of pregnancy on request, but also through the twentieth week of pregnancy on very broad grounds, including socio-economic grounds. Although the preamble to the law stresses that termination of pregnancy is not considered a form of contraception or population control measure, it also makes clear that the law is firmly based on the notion of individual human rights.

Nevertheless, opposition to the law has persisted. Shortly after its approval, the Christian Lawyers Association and other right-to-life groups brought an action against the Government claiming that, in authorizing the taking of life, the law violated the right to life of human beings, which, they asserted, starts at
conception. They based their claim on Section 11 of South Africa's new Constitution, which provides that "everyone has the right to life," arguing that the phrase "everyone" applies to an unborn child. In 1998 in a procedural ruling before trial, the Transvaal Provisional Division of the High Court dismissed the suit (Christian Lawyers Association v. Minister of Health, 1998). It held that there was no express provision in the Constitution, including Section 11, affording the foetus or embryo legal personality or protection and that to interpret "everyone" as encompassing a foetus would ascribe to the word a meaning different from that which it bears everywhere else in the Constitution. Moreover, the Court concluded that to afford the foetus the status of a legal person might impinge on the rights of women that are expressly guaranteed in the Constitution. Although the ruling constitutes a forceful endorsement of the Termination of Pregnancy Act, the issue has not been fully settled since the plaintiffs have appealed against the decision.

After the reform of the law, the number of legally performed TOPs rose quickly. Within the first six months (January to June 1997), the number of TOPs reported was twice that of the total number legally conducted during the eight-year period 1984-1991. The termination of pregnancy rate was estimated in 1997 at 2.7 TOPs per 1,000 women aged 15-44.

The South African Government views the fertility rate as too high. It has expressed particular concern about the high level of adolescent fertility and illegal termination of pregnancy. The Government target is to reduce the total fertility rate from 3.3 births per woman in 1995-2000 to 2.1 by 2010 and to increase contraceptive use from 48 per cent (as estimated in 1988) to 80 per cent of fertile women. The Government supports family planning services, and contraceptives are provided free of charge at all government medical establishments (Reproductive Rights Alliance: 2002).

What is therapeutic termination of pregnancy?
In general the term termination of pregnancy (TOP) refers to the termination of a fetus before it has attained viability, that is, before it has become capable of
independent extra-uterine life (World Health Organization, 1997). Roche (2004) defines termination of pregnancy as the termination of pregnancy before fetal viability in order to preserve maternal health, i.e. it can be performed to save the life of the mother, preserve the health of the mother, terminate a pregnancy that would result in the birth of the child with defects incompatible with life or associated with significant morbidity, terminate a non-viable pregnancy or selectively reduce a multi-fetal pregnancy. Roche (2004) further states that the decision to terminate a pregnancy for medical indications is generally a multi-disciplinary decision involving the obstetrician, a specialist in the disease entity in question, the patient, the patient’s family, psychologist, psychiatrist, ethicist, the nurses, spiritual counselors, intensive care specialists and the others.

Roche (2004) emphasizes that the decision to terminate the pregnancy should include considerations of the effect of the pregnancy on the disease outcome, the effects of treatment on fetal outcome, the gestational age of the pregnancy, the desires of the patient and the father, and the availability of the family resources and support. This complex situation requires thought and excellent communication among the involved parties regarding the short and long-term consequences of the decision to abort or continue the pregnancy, and the decision must be individualized for each patient.

Mayr, Wen & Saw (1998) list the commonly accepted medical indications for the therapeutic termination of pregnancy as severe hypertensive vascular disease, cardiac disease with cardiac decompensation and certain malignancies. Cervical cancer is the most common malignancy affecting pregnant women. Invasive cervical cancer is treated with surgery or radiation and both these treatment modalities result in fetal death for the pre-viable fetus (Mayr et al, 1998).

The diagnosis of being affected by the Human Immuno-deficiency Virus (HIV) adds yet further complications to any decision a woman makes whether to continue a pregnancy or not. A woman infected with HIV has the knowledge that her own life may be curtailed or marred by ill health during the baby’s childhood. As so starkly stated by Sunderland, Minkoff, Handtes, Moroso and Landesmas (1992), these women will determine the scope of the pediatric HIV epidemic.
The deliberate ending of a pregnancy continues to be the source of social and legal discord, moral uncertainty, medical and psychiatric confusion and personal anguish. Opponents of termination of pregnancy argue on moral, religious and even political grounds. The fair position in these arguments is that women must come to their own decisions armed with all the relevant facts and that they are entitled to help on the same basis as in any other situation where they seek medical help that is freely available under the health services (Roche, 2004).

The termination of pregnancy statistics in South Africa:

- During 2001, 45 449 TOPs were performed in South Africa.
- 18 725 of these TOPs were performed in Gauteng.
- The province with the termination of pregnancy figure closest to this is the Western Cape with 5920.
- Since the legalisation of termination of pregnancy in South Africa, approximately 220 000 pregnancies has been terminated (Doctors for Life, 2003).

Types of termination of pregnancy procedures

Although the term termination of pregnancy is often used to describe a single procedure, there are varying medical procedures, which are used to terminate a pregnancy (Carlson, Eisenstat and Ziporyn, 1996).

Very early termination of pregnancy

Between the first five and seven weeks, a pregnancy can be terminated by a procedure called menstrual extraction. This procedure is also sometimes called menstrual regulation, mini-suction, or pre-emptive termination of pregnancy. The contents of the uterus are suctioned out through a thin plastic tube that is inserted through the undilated cervix. Suction is applied either by a bulb syringe or a small pump. According to Carlson, Eisenstat and Ziporyn (1996) menstrual extractions are safe, but because the amount of fetal material is so small at this stage of development, it is easy to miss. This result in an incomplete termination of pregnancy that means the pregnancy continues.
First trimester termination of pregnancy

The first trimester of pregnancy includes the first thirteen weeks after the last menstrual period. This is the safest time in which to have termination of pregnancy, and the time in which women have the most choice of how the procedure is performed (Carlson et al, 1996).

Medical termination of pregnancy

Taking medication that ends the pregnancy brings about medical TOPs. Advantages of the first trimester medical termination of pregnancy are that the procedure is non-invasive i.e. no surgical instruments are used. Anesthesia is not required, drugs are administered either orally or by injection and the procedure resembles a natural miscarriage.

The disadvantages of medical TOPs are that the effectiveness is decreased after the seventh week; the procedure may require multiple visits to the doctor, bleeding after the termination of pregnancy last longer than after a surgical termination of pregnancy and the woman may see the contents of her womb as they are expelled.

Two different medications can be used to bring about termination of pregnancy. Methotrexate works by stopping fetal cells from dividing which causes the fetus to die. On the first visit to the doctor, the woman receives an injection of Methotrexate. On the second visit, about a week later, she is given misoprostol, an oxygenated unsaturated cyclic fatty acid responsible for various hormonal reactions such as muscle contraction that stimulates contractions of the uterus. Within two weeks, the woman will expel the contents of her uterus, ending the pregnancy. A follow up visit to the doctor is necessary to ensure that termination of pregnancy is complete (Carlson et al, 1996).

With this procedure, a woman will feel cramping and may feel nauseated from the misoprostol. According to Carlson, et al (1996), this combination of drugs is 90-96% effective in ending pregnancy.
Mifepristone is another drug used. It works by blocking the action of progesterone, a hormone needed for pregnancy to continue. On the first visit to the doctor, a woman takes a Mifepristone pill. Two days later she returns and takes two misoprostol pills, then after an observation period returns home. Within four days, 90% of women have expelled the content of their uterus and completed the termination of pregnancy. Within 14 days, 95-97% have completed the termination of pregnancy. A third follow-up visit to the doctor is necessary to confirm that the procedure is complete. In the event that it is not, surgical termination of pregnancy is performed.

**Surgical TOPs**

First trimester surgical TOPs are performed using vacuum aspirations. The procedure is also called dilation and evacuation (D & E), suction dilation, vacuum curettage, or suction curettage.

Advantages of a vacuum aspiration termination of pregnancy are that it is usually done as a one day outpatient procedure, the procedure takes only 10-15 minutes, bleeding after termination of pregnancy last five days or less, and the woman does not see the products of her womb being removed.

Disadvantages include the fact that the procedure is invasive, surgical instruments are used, and also that infection may occur. During a vacuum aspiration, expanding rods gradually dilate the woman's cervix.

Mansour and Stacey (1994) warned that women need to be informed of the small health risks involved in termination of pregnancy which are dramatically increased when the termination of pregnancy is delayed beyond the first trimester. Some women assume that if they have complications, this means that the operation has been done badly.

The physical complications of a surgical termination of pregnancy can include uterine perforation, haemorrhage, and anaesthetic risk, damage to the cervix and infection that may, if untreated, lead to infertility (Mansour and Stacey, 1994).
The two authors advise that in practice, if the termination of pregnancy is carried out in a well-equipped clinic before twelve months gestation, there are very few complications. From twelve to eighteen weeks prostaglandin termination of pregnancy is associated with more reaction to drugs used and haemorrhage than dilation and evacuation while this method has more risk of uterine injury.

**Circumstances and conditions in which pregnancy may be terminated**

In South Africa, the *Choice on termination of pregnancy Act of 1996* states that a pregnancy may be terminated upon the request of the woman during the first twelve weeks of gestation period of her pregnancy. Or/and from the thirteenth up to and including the twentieth week of the gestation period if a medical practitioner, after consultation with the woman, is of the opinion that the continued pregnancy would pose a risk of injury to the woman's physical or mental health, there exists a substantial risk that the fetus would suffer from severe physical or mental abnormality, or the pregnancy resulted from incest or rape, or the continued pregnancy would significantly affect the social or economic circumstances of the woman. The act also states that a medical practitioner may only carry out the termination of pregnancy.

The act emphasizes the importance of informed consent of the pregnant woman. No consent other than that of the pregnant woman shall be required for the termination of pregnancy. In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family member or friends before the pregnancy is terminated, provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

**Post-termination of pregnancy trauma**

Reardon (1998) wrote an article on experiences of termination of pregnancy and on who is at risk of post-termination of pregnancy trauma. Reardon (1998) argued that the number of women who suffer from post termination of pregnancy trauma is unknown, but in his study on this subject he identified the
characteristics of women most likely to suffer severe post-termination of pregnancy trauma, these are the women who feel pressured into having termination of pregnancy and those who feel uncertain or ambivalent about their choice.

Women who feel pressured to have termination of pregnancy, according to Reardon (1998) form a high risk. They go for termination of pregnancy in order to comply with the needs of others, especially if the wishes of others are experienced as coercion whether subtle or overt, e.g. threatening to withhold love or approval unless she “does the right thing.” Even lack of emotional support to keep the pregnancy may be experienced as pressure. In addition pressure from adverse circumstances such as financial problems, being unmarried, social problems or health problems may also make a woman feel she is being forced to accept termination of pregnancy as her only choice (Reardon 1998).

Reardon (1998) also states that there is a group of women which is reluctant to have termination of pregnancy the source of doubt may result from either conflicting moral views about termination of pregnancy or from conflicting desire to keep the baby.

Ashton (1980) argued that the majority of women seeking termination of pregnancy feel pressured to do so, yet at the same time they experience moral qualms about termination of pregnancy itself and/or feel maternal desires to protect their pregnancies. Therefore for these women termination of pregnancy is not a glorious right by which they are able to reclaim control of their lives, instead it is an “evil necessity” to which they submit because they have “no choice.”

Ashton (1980) further argues that rather than affirming their own values, these women feel forced to compromise their values, rather than feeling proud of themselves for standing up against difficult situations. They feel ashamed of themselves for being “spineless cowards.” This feeling of self-betrayal is a devastating blow to the woman’s self-image and her feeling of self worth. Reardon (1998) argues that while many high-risk women will begin experiencing negative emotional and behavioral patterns soon after termination of pregnancy,
these problems are frequently blamed on people, situations, or circumstances other than termination of pregnancy. During this time Reardon further explains that the high-risk woman may go to great lengths to avoid people, situations, or events, which she associates with her termination of pregnancy. She may even be vocally defensive of termination of pregnancy in order to convince others and mostly herself that she made the right choice and is satisfied with the outcome.

Termination of pregnancy counseling
Adequate counseling should be offered to all who need to make a decision concerning a pregnancy, because counseling provide time for exploration, discussion, information, explanation and advice.

Many women feel uncomfortable or unable to talk with friends and relatives. Therefore professional counseling offers a valuable and much needed resource. Van Dyk (2001) defines counseling as a structured conversation aimed at facilitating a client's quality of life in the face of adversity. It is an umbrella term, which includes advice, information, support, education and therapy. It is important that various types of counseling be given to a woman at the right time and all information should be confidential. Ideally counseling offers a woman who is considering termination of pregnancy a non-judgmental and non-directional opportunity to work through her feelings and thoughts. A woman considering termination of pregnancy should be able to discuss and explore her difficulties in an informal and unhurried manner. In some cases, the partner or parents also request access to counseling.

Numerous studies have shown that women are more likely to experience negative emotional outcomes if they feel the decision to end the pregnancy was not fully theirs to make (Australian National Health and Medical Research Council, 1996). In any counseling situation, the central aim is to respect the woman's autonomy and facilitate her independent decision-making. Therefore counselors need to be empathetic and highly trained in interpersonal skills.
Counseling should support the woman to make a free and fully informed decision about her pregnancy options. This includes offering information about alternatives like keeping the child or giving the child up for adoption, in situations where the woman has not yet made up her mind. According to Teng (1999), if a woman feels she has made the right decision, she will rarely request follow-up or therapeutic counseling.

Details on the logistics of the operation including what to expect, how long it takes and the related costs should be offered to all women seeking termination of pregnancy as a matter of course. The women will need to discuss such issues as the procedure itself, anesthesia options, and pre- and post-operative care. Part of the decision making process includes being fully informed of the associated risks (Brien and Fairbairn, 1996).

Teng (1999) argued that after termination of pregnancy some women want to talk about their experiences to a sympathetic counselor. Although follow-up counseling is offered, or should be offered to all women, some decide not to take it. In the post-termination of pregnancy counseling, issues such as physical and emotional recovery and contraceptives options should be discussed.

The National Health and Medical Research council of Australia (1996) found out that for some women the experience of an unplanned pregnancy and subsequent termination of pregnancy is highly traumatic. Feelings of guilt, grief, shame, depression and anxiety need to be handled by highly trained and skilled counselor. Appropriate counseling can minimize the risk of long-term psychological harm (David, 1974).

Teng (1999) further argued that not all women benefit from counseling. Some women have reported that while the thought of termination of pregnancy was not initially traumatic, it became so during the counseling process. The doctors, counselors and related health care professionals in these cases tended to pass judgement and try to impose their own moral, ethical or religious beliefs. In some instances, incorrect or misleading information was given about the procedure.
This was interpreted by women as attempts to scare them into changing their minds.

Who should provide counseling?

A wide range of health professionals and lay people undertake pregnancy counseling today, not all of who receive counseling supervision or are trained counselors. Ideally a pregnancy counselor needs the foundation of training in counseling, preferably to diploma level (Alien, 1985). Diploma courses carefully recruit and select their counseling students using procedures designed to ensure that the student has sufficient ability to cope with emotional stress, is able to reflect, can demonstrate self-awareness and maturity skills.

According to Alien (1985) it is important that the pregnancy counselor is able to allow exploration of feelings without reacting or being defensive about the client's judgement and assumptions. In this way the counselor does not add to the stigma, isolation or anxiety that a woman may be feeling. Ending potential life is still seen by most people as shameful and taboo. If clients feel the counselor is not "on their side", this can inhibit decision-making or add to their tension by increasing feelings of guilt and rejection (Hare and Haywood, 1981).

Who should receive counseling?

Any woman can be unhappily pregnant and benefit from an opportunity to talk. For many women this may be the only time they see a counselor, and some women are unused to communicating complex feelings in words.

Ashton (1980) identified clients who can especially benefit from counseling as adolescents, those who have not started or completed mourning past losses, those suffering from depression or with a history of mental health problems, those with a history of gynaecological problems, those with a history of repeat terminations of pregnancy, stillbirth, difficult births or miscarriages, those who are highly anxious or show a marked calmness which is inappropriate to their situation, those who feel or have felt unwanted, those who have been emotionally, physically or sexually abused, those with eating disorders,
addictions and compulsive behaviors and those having terminations for medical reasons.

Corney (1990) advised that many approaches can be used in counseling, but the most suitable approach is one that lessens threat and enables the focus to be kept on the client’s needs. Whatever the theoretical background of the counselor, he or she will need to set the boundaries of the counseling relationship, offer uninterrupted time, preferably of a stated length, and outline the total duration of time available for counseling, and to make clear the limits of confidentiality and access to the counselor. The counselor’s task is to create a sufficiently welcoming space, rapidly build a working relationship and demonstrate respect for the client. Once the client has decided to continue or terminate pregnancy, the counselor helps the client to accept and deal with the possible consequences of this decision.

Post-termination of pregnancy counseling

A pregnancy that ends in a termination is a major transition for a woman, no matter how correct or straightforward her decision was, her life has changed irreversibly (Brien and Fairbairn, 1996). Many women can integrate this experience, feeling secure about the decision they had to make. They are able to cope with the varied complex feelings a termination of pregnancy may evoke. They can acknowledge the relief that the termination of pregnancy offers as well as the pain of the lost pregnancy; they are able to live with their decision and its consequences.

Kent (1977), a post-termination of pregnancy researcher, reported that the only positive emotion many women experience after termination of pregnancy is relief. Temporary feelings of relief are frequently followed by a period of emotional paralysis or numbness. Kent (1977) further explained that these women are unable to express or even feel their own emotions. Their focus is primarily on having survived the ordeal and they may be at least temporarily out of touch with their feeling.
Dagg (1991) however, observed that other women, for a variety of reasons find the experience so unsettling that they ask for the opportunity to talk with a counselor in an attempt to gain some understanding of the gamut of feelings they are facing. Some of these women seek counseling in its own right, others may be discovered when they attend for their post-termination of pregnancy check-up or in contraceptive consultation. Dagg (1991) realized that there has been some concern that the offer of post-termination of pregnancy counseling may create problems for women by implying that they should be experiencing some adverse psychological effects; but the main aim of this appointment is not to dig up and unearth hidden wounds. It is for validating a woman’s experience and giving her “permission” to talk about her feelings if she so wishes.

Most women are not able to express themselves openly pre-termination, having had to keep a firm grip on themselves in order to go through with the procedure. This according to Dagg (1991) makes it more difficult to return and be open to those from whom they had to hide their feelings. Some women may be angry or have other very strong feelings about the termination center, but others find it helpful to continue working with someone who has supported them through the whole thing.

Brien and Fairbairn (1996) argued that the request for counseling might be precipitated by a wide variety of symptoms, anytime from a few days to many years after termination of pregnancy. According to these two authors, themes that are common include crying all the time and feelings of incredible loss, nightmares about dead babies, panic attack, and intolerable envy of women with babies and overwhelming guilt. Women may also have distorted reactions to the termination of pregnancy that may take much unraveling, these include general depression and low self-esteem, relationship or sexual problems and somatic complaints. They may arrive for counseling apprehensive, hostile, in turmoil or grief-stricken.

One may wonder what a woman needs when she comes for post-termination counseling. The basic idea is that she comes with some hope that here she will have her feelings about her termination of pregnancy experience honoured and
respected. Therefore basic counseling conditions are important in order for woman to feel as safe as possible. The counselor needs to be non-judgmental and willing to fully engage with the woman so that her world can be shared in the session.

**Emotional legacy of termination of pregnancy**

One of the commonest emotions seen after a termination of pregnancy is sadness. All women attending post-termination of pregnancy counseling have suffered an extremely complicated loss, which makes grieving harder. The women themselves have made a decision to end a potential life and they can feel as though they have no right to mourn. Some even feel that if they acknowledge their sadness it could mean that they have made the wrong decision. Natural sadness may therefore be lost in the primary need to show no regret, which in turn may cause blocked, stifled feelings and eventual depression.

Feelings of loss are overwhelming and can bring agony. They can be experienced more violently than physical pain. Colin Murray Parkes (1972) through his pioneering work advised that grief needs to be expressed, and the process of coming to terms with loss worked through. Through his work it is now apparent that the bereaved person need to go through certain phases. These stages can include shock, numbness, denial, pain and disorganization, before eventual acceptance and reorganization.

One of the ways we defend ourselves against pain is to deny what has happened (Brien and Fairbairn, 1996). This is an adaptive way of dealing with sudden change and loss. It is impossible for the person to take in so much pain at once, so the stark reality is blocked. In the short term this could be life saving but, at its most extreme, result in mummification, as seen in those bereaved people who leave the dead person's room just as it was before the death. The secrecy surrounding termination of pregnancy appears to be one of the factors that make denial a particular problem. Panic attacks, dreams and nightmares, regrets, envy, guilt and anger are other emotion that can be expected from a woman who has had termination of pregnancy.
Many relationships may change for a woman following her termination of pregnancy. She may be too ashamed to tell her friends or she may confide in them and then be let down by their response. Sometimes when the women is still at home and has told her parents about the termination of pregnancy, there often needs to be readjustment within the family. Having a termination of pregnancy is absolute proof of sexual activity and parents can no longer deny that their little girl is growing up. The transition may be extremely hard for all of them. Many young women are given tremendous support by their parents but some may be less lucky and be at the receiving end of the family's projections and shame.

**The Natural Law Ethical Theory**

In the paper written by Irving (2000) on the Natural Law Ethical Theory, she argues that the rhetoric on termination of pregnancy continues to embattle and confuse "prochoice" and "pro-life", "liberals" and "conservatives" alike. According to her, many "liberals" complain that it is irrational and brutal to expect a woman to die so that her unborn child may live. Termination of pregnancy should be permitted basically on demand, certainly in cases where the health and life of the woman is at risk, and even in cases of incest or rape. Besides, Irving reminds us, it is legal. She further explains that in contrast, many "conservatives" argue that termination of pregnancy can never be rationalized or permitted, as it is fundamentally immoral to kill an unborn child who is an innocent human being, no matter what the circumstances or the law - regardless of the woman's health, life, incest or rape. At times it seems that the advocates of either position are "talking past" each other, oblivious to the possibility of any moral legitimacy in each position. Irving (2000) further explains that there seems as yet to be no structured or principled means by which to circumvent this highly politicized stand-off or to address these tragic moral dilemmas which after serious consideration are commonly acceptable to both "camps".
To a significant degree Irving (2000) argues that this stand-off is often due to misinformation or to a reluctance to make some important moral distinctions. One moral distinction is between: inherently bad actions (e.g., termination of pregnancy); and, inherently good (or neutral) medical actions which are permitted, even though bad effects would result, in order to save the life of the mother (e.g., the giving of chemotherapy treatments, or the removal of a cancerous uterus, etc.). Another moral distinction is between directly and indirectly voluntary actions (that is, between directly "willing an evil", and indirectly allowing "an evil" to take place).

According to Irving (2000) once these important moral distinctions are correctly understood, then conditions allow us to apply a common moral principle to this stand-off, rather than leaving such a vital issue up to personal emotions or to unprincipled political compromise. The common moral principle often used in these difficult situations is that found in the time-honored theory of natural person, known as the Principle of Double Effect, which was discussed by Cataldo in 1995. Properly understood, the Principle of Double Effect evolved in order to address just these types of difficult moral dilemmas - in this case where both of the lives of those affected are innocent, and yet something must be done or will happen which inevitably will endanger one of these two innocent lives.

According to Cataldo the obvious application of the Principle of Double Effect for our purposes here is when a woman, who is herself an innocent human being, whose human life is precious and must be respected, is pregnant with an unborn child, who is likewise an innocent human being (from fertilization onwards), and whose life is also precious and must be respected.

Since, as the Natural Law Ethical Theory holds, one may never directly intend to kill an innocent human being (Irving, 2000), under what circumstances and conditions is it morally permissible: for a woman to undergo an termination of pregnancy procedure; or for a physician to help one of these innocents to live, by means of other and different morally
legitimate medical actions, and yet permit or allow the other, unfortunately, to die?

As Cataldo further argues, these are really two different and separate moral questions, and so must be approached differently. One concerns termination of pregnancy procedures; the other concerns other medical actions or procedures which could be taken in order to save the life of the mother (and vice versa) when urgent and valid medical circumstances arise. Cataldo (1995) suggests that the solutions to these two very different questions, could be applied in helping to resolve at least the extremes of the current termination of pregnancy debates, without at all compromising long established moral principles. Cataldo strongly feels that the resolution lies in seeing the moral distinction between these two questions, and then properly applying the well-established Principle of Double Effect.

But before developing this often used application of the Principle of Double Effect in more detail, it is important to stave off just a few possible objections by clarifying quite briefly some facts about Natural Law Ethical Theory - a theory often misunderstood, misinterpreted, or misapplied down through the years.

One may wonder what this Natural Law Ethical Theory is. Irving (2000) in her paper explained the principles of this theory and why she felt that it could be very useful in understanding and dealing with the termination of pregnancy debate. Firstly she argued that it is a philosophical ethical theory, not a theological one - although it can be and is related to theology. That is, Natural Law Ethical Theory aids us in understanding which human actions are morally right or wrong through the aid of human reason alone - without the use of divine revelation. It has been studied and refined over the centuries as a means of addressing what is the morally right thing for us to do when faced with genuine moral dilemmas. It is not some new, brash, untried or unscrutinized moral theory. One might agree that although Natural Law Ethical Theory is by definition not a case of
imposing one's religious or belief system on others, it still might be objected that it is a case of imposing one's ethical system on others.

Secondly, in counter-distinction to many other ethical theories, Natural Law Ethical Theory is proximately and objectively grounded in our objectively knowable human nature, i.e., on what is really good or bad for us as human beings - as individuals and as members of our human communities. It is not simply deduced from non-empirically derived and questionable "philosophical" premises or religious dogmas, or from variable emotions or personal opinions. For example, it is wrong to use hard drugs because our human natures are such that drugs eventually seriously harm, sometimes even destroy, us - body, mind and spirit. They can also seriously harm others close to us as well as to our human society at large. That is just the way we human beings are "made"; and we can know this fact objectively and empirically.

Thirdly, because the basic precepts of Natural Law Ethical Theory are proximately grounded in an objectively knowable human nature, they are applicable to all human beings, precisely because we all possess such human natures. The possession of natures which are specifically human is precisely what we all have in common. This is true regardless of time, culture, background, race, sex, religion or political affiliation.

Thus if properly understood and applied, Natural Law Ethical Theory should be ideal for our "pluralistic" society - since all of our citizens are human beings, and hold at least that in common. What is fundamentally good or bad for human beings in general will hold for us all. Certainly secondary differences must be taken into consideration; but the primary precepts of the natural law will be the same for all of our citizens by virtue of their common humanity, and these precepts cannot be changed because our human nature, and what is objectively and fundamentally good or bad for it, cannot change. It calls, indeed, for simply minimal moral requirements to guide a human polity.
Finally, in Natural Law Ethical Theory, there are three determinants of a human action which determine its rightness or wrongness, and all three determinants must be good in order for an action to be considered good (Irving 2000). Firstly the act itself (what the agent wills), which is either good, evil, or neutral (indifferent) by its very nature. For example, the act of termination of pregnancy is per se evil; the acts of administering chemotherapy or performing a hysterectomy could be inherently good, or indifferent (neutral), actions.

Secondly the motive or intention (consciously willed), which is what the agent wants to achieve by the act - i.e. the end, purpose or goal of the action; why the action is performed - e.g. in order to kill a person; or in order to evade social disgrace, better spacing of children, or cure a deadly disease.

Thirdly the circumstances, which are the accidental surroundings of the act, which include the consequences of the act - e.g., the act of intercourse with a willing spouse or forcibly with a stranger or one's child; or that there are no other medical treatments available.

Irving (2000) emphasizes the critica to understand that an action which is evil in itself (by its nature) cannot be made good or indifferent by any intentions, goals or circumstances - no matter how good or praiseworthy these are per se. On the other hand, an action which is good in itself (by its nature) can be morally ruined by any gravely bad intentions or circumstances. These three determinants of a moral act are explicitly incorporated into the following short explication and clarification of the Principle of Double Effect.

The Principle of Double Effect:

Cataldo (1995) explains that the part of Natural Law Ethical Theory referred to as the Principle of Double Effect was gradually refined over the centuries in order to meet the unfortunate but very real moral dilemmas in which, no matter what is reasonably done, one or more innocent human
beings may be harmed or even die in the process of resolving the dilemma. The following explication of the Principle of Double Effect, as well as its four necessary conditions, are taken almost verbatim from the work of Austin Fagosty, Right and Reason 1963. Its application to the termination of pregnancy debate will be specifically indicated under each condition of the principle.

The Principle of Double Effect is based on the fact that evil must never be directly and voluntarily willed for its own sake, and must never be willed either as an end or as a means to an end. Nor may evil ever be directly willed as a foreseen but unwanted consequence. But evil can be reduced to an incidental and unavoidable by-product in the achievement of some morally licit good the person is rightfully seeking.

Thus, although a person is never allowed to will evil, he/she is not always bound to prevent the existence of evil. Just as he/she may tolerate the existence of evils in the world at large, since he/she could not cure them without bringing other evils on him/herself or his/her neighbour, so he/she may sometimes tolerate evil consequences from his/her own actions, if to abstain from such actions would bring a grave evil on him/herself or others.

Unfortunately, then, as is sometimes the case, he/she cannot realistically in fact will a legitimate good, without at the same time permitting the existence of an evil which in the very nature of things is inseparably bound up with the good will. But he/she must not do so indiscriminately. In short, sometimes he/she is bound to prevent evil, and in these cases it would be wrong for him/her to permit it. But sometimes he/she is permitted to allow evil effects to take place. How can we distinguish between these two different cases? This is where the Principle of Double Effect comes in.

The Principle of Double Effect according to Cataldo (1995) holds that it is morally allowable to perform an action that has a bad effect only under the following conditions:
the action to be performed must be good in itself, or at least indifferent. This is evident, for if the act is evil of its very nature, nothing can make it good or indifferent. Evil would then be chosen directly, either as an end or as a means to an end, and there could be no question of merely permitting or tolerating it. If the action is fundamentally and inherently morally illicit, then it cannot be morally permitted regardless of any good intentions or goals, or under any circumstances.

Application: The act of termination of pregnancy of its very nature is inherently evil, because it is the intentional and direct killing of an innocent human being. This would apply to all termination of pregnancy, including those in the case of rape and incest (and to those involving human fetal and human embryo research, and human cloning). Therefore it is never morally permissible to undergo an termination of pregnancy procedure. The Principle of Double Effect as applied to the case of termination of pregnancy renders termination of pregnancy procedures morally illicit, since the action by its very nature is evil. However, other possible medical actions, e.g., the giving of chemotherapy or the removal of a cancerous uterus — morally good or at least neutral acts — could be permitted in order to save the life of the mother, even if it could possibly result in the unintended death of the unborn child, as long as all of the other three following conditions are also met.

The evil effect must not be directly intended for itself but only permitted to happen as an accidental by-product of the act performed.

Application: In the case of termination of pregnancy procedures, the death of the unborn child is directly intended, and therefore is morally illicit. On the other hand, in the use of chemotherapy or the performance of a hysterectomy to remove a cancerous uterus, etc., the death of the unborn child may not be directly intended, but only permitted or allowed as a possible by-product.
The good intended must not be obtained by means of the evil effects. The evil must not be an actual factor in the accomplishment of the good.

Application: In the case of termination of pregnancy procedures, the death of the unborn child may not be used as a means of limiting family size, preventing birth defects, enhancing a career, etc. (all legitimately good or neutral ends or goals in themselves). On the other hand, the curing of the potentially deadly disease of cancer could be obtained by means of the morally acceptable actions of the administration of chemotherapy or the performance of a hysterectomy. The death of the unborn child is not the means used to cure the cancer.

There must be a reasonably grave reason for permitting the evil effect. If the good is slight and the evil great, the evil can hardly be called incidental. If there is any other way of getting the good effect without the bad effect, this other way must be taken.

Application: In the case of termination of pregnancy procedures, to maintain a slim figure, to have a child of a certain sex, to prevent the birth of a child with defects, or to evade social embarrassment would not be reasonably grave reasons for permitting the unintended and unavoidable death of the unborn child. On the other hand, to give chemotherapy or to perform a hysterectomy in order to remove a cancerous uterus, etc., to preserve the life of the mother (who is also an innocent human being) would be a reasonably grave reason for permitting or allowing the unintended and unavoidable death of the unborn child. If there is any other reasonable medical treatment available to save the life of the mother which would not entail harm to or death of the unborn child, then it must be chosen instead.

Comment

In response one could point to several facts: firstly, Natural Law Ethical Theory can well hold its own in complicated, academic and heated
debates compared to other philosophical ethical theories. Secondly, there is simply no such thing as a “neutral” ethics which might be “perfect” for our pluralistic society – no matter how convenient such “neutrality” might be. This includes the ethical theories of utilitarianism, relativism or communitarianism – none of which are “neutral” and all of which are normative ethical theories. Therefore we are in fact constantly “forcing” some non-neutral philosophical or social ethical theory on others in this country, whether we want to acknowledge that fact or not. Finally, as pointed out in the “Declaration on Procured Termination of Pregnancy” (1974): It is true that it is not the task of the law to choose between points of view or to impose one rather than another. But the life of the child takes precedence over all opinions. One cannot invoke freedom of thought to destroy this life.

In short, a pregnant woman who is faced with the grim reality of impending death short of the use of, e.g., chemotherapy or hysterectomy, may use these and other morally licit medical treatments an procedures for the reasonably grave reason of saving her life, as long as the death of her unborn child is not directly intended as the end (or purpose) of using these procedures, or is the means by which her life is saved, but only allowed or permitted to happen as an accidental by-product of these medical actions, and no other reasonable medical treatment is available. However, the directly intended death of an unborn child by means of procured termination of pregnancy remains morally indefensible – even to save the life of the mother, or for the best of intentions, or under very difficult circumstances – even in the case of incest or rape.

There is too much at stake to leave the lives of so many millions of innocents – both women and unborn children – up to mere personal whimsy or political bartering. The social fibre in this country has been shattered and stretched to the limit. Presented here is at least a common moral means of considerably reducing the misinformation swirling about these termination of pregnancy debates. The proper understanding and application of the Principle of Double Effect offers a commonly accepted, morally legitimate, objectively grounded basis for clarifying
the important moral distinctions which need to be made within these very tragic and difficult moral dilemmas – one on which most of us could reasonably agree.

**Feminist view on termination of pregnancy**

Although this is not THE feminists view it represents a view that many feminists hold. Fundamental to the pro-choice/termination of pregnancy case is the claim that a woman has an absolute right to terminate a pregnancy because she should have the right over her own body (O'Brien, 2001). Freedom of choice, however, is not absolute. One has the right to choose only between alternatives that are legally and morally permissible. The radical position in favour of termination of pregnancy is that the fetus is not a human being, so it is not the destruction of human life. The principle that one should respect life even when there is a dispute about the actual existence of life applies in all cases. O'Brien (2001) points out that, women frankly acknowledge that termination of pregnancy ends a life, but they feel that they have no alternatives. Termination of pregnancy usually is the sad refuge of one who feels trapped and who does what she would rather not do. It would seem that all possible and reasonable measures should be taken to reduce the frequency of mothers feeling that they have to abort their unborn child.

Feminists believe that the social situation of women justifies the view that individual women must be the only person to determine whether their pregnancies should end or continue. They also believe that the personhood of the fetus is a function of the social relations that exist between the woman and her fetus. The anti-feminist people may argue that the man is also responsible for the fetus.

**Conclusion**

Termination of pregnancy counseling can be the door through which a woman grasps the chance to find out who she is and what she wants from life. Most women who go for termination of pregnancy have never had any experience of counseling before. Hence termination of pregnancy can be the means through which a woman is catapulted to challenge some of her basic assumptions about
herself. The termination of pregnancy itself can just be the tip of an iceberg, which then acts as a catalyst for the woman to look at her basic self.
CHAPTER 3
Methods and procedures of investigation

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

Procedure
The questions used for the interview were designed using the stress and coping theoretical framework as a guide to elicit information about stress responses, coping, and resources. I began by introducing myself, and sharing relevant background information. The participants were asked to read and sign the informed consent (Appendix A) if they wanted to participate in the research. They were then asked to fill out the demographic questionnaire (Appendix B), which consisted of 10 short answer questions. The interview included 13 different questions. The first question was used to get the participant talking, and was basically, “what do you think would be important for someone who was studying termination of pregnancy experiences to know?” It was then followed more specific questions (Appendix C), and even if I felt the participant had already answered the question, clarification or more detail was elicited by the specific questions.

The questions covered a vast area of the participant's life which included information before the pregnancy up until the present.

The Interview
To obtain a retrospective viewpoint, direct interviews were performed. The interviews took place in a private room at the hospital. They were all face to face. All interviews on average lasted approximately 120 minutes.
Appendix C is the list of questions which were used to guide the interview. The questions were open-ended and were used to elicit information about the decision process, coping, and resources. The list was used as a guide for the interview, but as responses were collected, I used follow-up questions for more clarification or depth. I also used statements to clarify ideas or concepts that the participants were expressing.

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

Participant Selection

In order to obtain a balanced perspective, I tried to avoid recruiting participants who would be at extreme ends of the experience. For example I avoided posting notices about the study at religious or pro-choice businesses. I negotiated with Victoria hospital in Wynberg, Cape Town for referrals and also spoke to friends and colleagues to help me with recruitment.

I tried to share information about my research with as many people that I came into contact with as possible, in the hopes that someone might know someone who would be willing to participate in the research. The wait for participants to call was excruciating, three months passed and I had not received any calls from participant. I had to regroup and remind my colleagues and friends of my desperate need for their help.

The participants then started calling fortunately they were all over the age of eighteen except for one, for whom I had to ask her mother to sign consent on her behalf. They were all one year post termination of pregnancy. With the entire participant pool that met the criteria, I scheduled interviews at a time and place that was convenient to the participant.
Confidentiality

The identity of the women chosen for the study has been kept confidential throughout the entire research process. Their real names were never written on the questionnaires. At no time will the participants name be associated with the information they have given the interviewer. The participants were given pseudonyms, and any specific information, such as names of others or place names have been changed to protect their identity.

Participants

There were 6 participants who ranged between the ages of 17 to 42, the average age of the sample was 28. All participants were geographically from Cape Town.

The participants' ages ranged from 16 to 28 when the termination of pregnancy was performed, with an average age of 22.3. The length of pregnancy when they discovered that they were pregnant ranged from 8 weeks to 16 weeks, with an average of 10.1 weeks. The women ranged from 8 to 16 weeks gestation when their termination of pregnancy was performed, the average length of gestation was 10.5 weeks at the time of the procedure. Only 1 participant was married when termination of pregnancy occurred. All participants were Christians at the time of the termination of pregnancy, and they all still are.

Only one of the six participants is currently married, and 2 of them have children. Only one participant had children at the time of the termination of pregnancy. At the time of the interview, one participant reported that her young boyfriend desperately wanted to have a child but she felt they were both still very young to carry such a responsibility therefore went against his wishes and had the termination of pregnancy. All but two of the participants had matric at the time the termination of pregnancy occurred.
CHAPTER 4

Findings and discussion of the study

The following section is designed to give a description of each of the participant's unique experiences. Each participant's story is divided into three parts: before the termination of pregnancy, during the termination of pregnancy, and after the termination of pregnancy. The women's own words are used (in italics) to give a more accurate description of the narrative.

Coco

Before the termination of pregnancy

Coco is a 30 year old woman who grew up in a Zion Christian Church. Her mother is a housewife and her father is a labourer. She has 6 siblings. She had her termination of pregnancy two years before at what she thought was about 16 weeks gestation. Her pregnancy was a result of an affair she had with a married man. She related that terminating her pregnancy was a desperate measure. She didn't want to have a child with a married man, who made it clear that he also didn't want to have a child outside marriage therefore she must get rid of it. At the time she had a secretarial diploma and knew that she couldn't support the child with her income. She reported that before her termination of pregnancy she had always been highly critical of such people.

She said that when she found out that she was pregnant she didn't think about the after effects of termination of pregnancy

C: ....The most difficult part at the time was that I couldn't even pray to God for strength because I felt guilty knowing that I was about to kill an innocent child. I am a person who always relies on prayer as a coping mechanism during difficult times therefore during this time I felt naked and bare and till today I still ask myself how I managed. At the time I didn't trust anyone with my secret so it was just me and the doctor who discussed it. Everybody that I came across seemed so pure and I was the evil one.
R: If you had somebody to talk to other than the doctor do you think it would have made a difference?

C: It won't be easy to say now if it would have helped, this subject is very confusing because you want to tell people what you go through but at the same time you don't want them to know. Personally I knew what I was doing was wrong. Up till this day I still work hard to convince myself that I did what I had to but the guilt is sometimes debilitating. To talk to somebody who has never gone through what you have is not easy because as much as they may try to understand they will never really know what one goes through.

During the termination of pregnancy

Coco reported that she remembers that day as if it was yesterday. Her partner who had made her pregnant did not want anything to do with her therefore she had to take a taxi to the hospital. She relates that the journey felt like the longest she has ever taken. It felt like the other commuters knew what she was about to do. At the hospital the doctor's assistant afforded her a smile but her eyes weren't smiling. Everything was technical and not emotional. She remembers that during the procedure it felt like she was not there, she had left her body. This could be viewed as a dissociation to help her manage the stress she was experiencing.

After the termination of pregnancy

Initially after the termination of pregnancy, Coco describes feeling empty as if there was a whole in her body and soul. She also noticed that she got hungry more often and therefore ate a whole lot. This led her to gain a lot of weight but she says she doesn't mind being fat.

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

C: well the doctor made it sound really easy. You will have a minor discomfort for few days then you can go back to you life as normal. I have been through
difficulties before and came out of them a victor. Although I did not give it much thought before the procedure I hoped that I was going to be fine.

R: ...did you know about other options when you decided to terminate?
C: ... what other options I don't understand?
R: adoption, raising the baby....
C: ...no I didn't and I don't think it would have changed my mind as I knew that I had to get rid of the baby so that I won't get into trouble and most specifically so that my partner wouldn't get into trouble. If I kept the baby I would have brought shame to my family.

Coco relates that it has been two years but she still feels guilty about this, its not every day but every once in a while. When asked what would she do if she found herself in the same situation. Coco stated that she would never make such a decision again she would rather “face the music”. She hasn't forgiven herself for terminating.

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

C.... I did what I did because I was desperate maybe in another time and place I would not have made this decision. It has happened I still struggle to put it in my past. Oh... and I would like to lose a little weight ha ha ha (she laughs)

Lala

Before the termination of pregnancy
Lala is a 42 year old African lady who currently has 3 children and is not married. She is a primary school teacher. She had her termination of pregnancy 9 years ago. She discovered she was pregnant at 8 weeks, and had the termination of pregnancy at 10 weeks. When she found out about her pregnancy she knew that keeping the baby wouldn't be an option for her. She had completed her teacher's diploma but already had 3 children. As a single mother she was struggling to cope and felt the fourth child would add to the difficulty. She chose not to tell the
current boyfriend at that time as she felt he might insist that she keeps the child. She was raised in an Anglican Christian church and she still goes there.

Her decision to terminate was not difficult, she knew a lot of people who had terminated and came out of it okay. She also knew that she was still within the prescribed legal boundaries for any woman who wants to terminate.

R: .... how did you decide what options were available to you in making the decision to terminate?

L: .... at the time the only option was to either keep the baby or terminate. In our culture adoption is not big. You can't carry a baby for 9 months and then give it to a stranger just because you don't want it. If you choose to carry it then you keep it.

R:......Did you speak to anyone before you terminated?
L:..... Yes I spoke to my doctor and my friend who had had the termination.
R:..... I mean did you get counselling from the doctor or nurse?
L:..... Yes the doctor told me what he was going to do.
R:.....Did you understand what he was telling you?
L:..... Yes he told me that termination has become a very common procedure with very little chance of complications and that's all I wanted to know.
R:..... what did you predict would be your response to termination of pregnancy?
L:..... My main concern was the pain. I've heard stories about how painful it can get. I wanted to part with the problem and I knew I would be relieved.
R:..... Do you ever think about it?
L:..... No it is the past and my main focus is the future.
During the termination of pregnancy
Lala laughs when she remembers the day she went to the clinic for the procedure. Her laughter doesn't seem real, it is as if she is masking some emotions. She remembers that it was the first time she felt a little nervous about the whole process. It was the private clinic and she trusted the staff. As promised the procedure went well and it was over in no time.

After the termination of pregnancy
For Lala the quicker she forgot about the procedure, the better. She went back to work and put this incident in her past. She broke up with the father of the terminated baby and is currently dating someone else. Her three children are all grown up. She reported that she wants to change her job as she doesn't enjoy teaching young children anymore. When asked if it could be that she hates a job because she works with young children who maybe the same age as the child she terminated she denied it. When asked if she would do it again, she replied that she is too old to fall pregnant but if it happened she really doesn't know, she can't tell right now.

Peggy
Before the termination of pregnancy
Peggy is a 28 year old mother of two, she is married to a soldier and is unemployed. She has been married for 8 years. She is a staunch Christian. Although she is not working her husband is providing for her. Her marriage was not at its best at the time of termination of pregnancy as her husband was physically abusive and used alcohol. She was 26 at the time of termination of pregnancy. She reported that she was using birth control but it failed. She realised that she was pregnant at 8 weeks. Pregnancy did come as a surprise but she was a married woman so she accepted it.

During the procedural blood test she discovered that she was HIV positive. This came as a shock to her. She remembers that she forgot about pregnancy at that moment and only saw death in front of her. The person who did counseling for
her at the time told her about the risks of continuing with pregnancy when one is HIV positive and that many women opt for termination to avoid complications. She then opted for termination.

R:.....how did you decide what options were available to you in making the decision to terminate?

P:.....At the time termination was the humane thing to do, as the counselor had advised, it was the best way to protect me and the unborn baby from this disease. I don't like to gamble so I told the nurse I would terminate.

R:....... What about your husband, wasn't he part of your decision making?

P:..... To be honest, when I made the decision he was not even on my mind. I really felt alone in the world and had to fight this battle. If it wasn't for him I wouldn't even be faced with making such a decision.

R:..... What do you mean?

P:.....Who else could have brought this illness into my life? I'm not happy with the way he treats me, his drinking and now this.

R:.....Before this incident, what were your beliefs about termination of pregnancy

P:.....I am a Christian and killing is a sin. Therefore I have always been against termination of pregnancy. I never thought in my life I would do such a thing... (she sobs)

She remembers that when she got home her husband was drunk and she still told him about the HIV and what was recommended at the clinic. The husband was not supportive and told her to do whatever suits her. She related that this was the most difficult time for her. Having discovered that you are pregnant when you were not planning to, being told that you are HIV positive and now faced with termination of pregnancy, and the pressure to make the decision to terminate sooner because if one waits longer weeks accumulate and the riskier it becomes to terminate.

P:..... I felt trapped. I felt very frightened. The whole experience was numbing I wished my mother could have been still alive, so that I could speak to someone I
trust and someone who knows me and my beliefs. The counselor did explain that there is a chance that the child might be negative. I let my fear help me make the biggest decision of my life. Maybe I am a bad person. My husband tells me everyday. There is no single day that goes past that he doesn't tell me that I killed his child. Maybe I shouldn't have, maybe I should have taken a chance. It is really hard.

During the termination of pregnancy
Peggy remembers that when she went for termination her husband came with her. She asked him if he was ok with the whole decision, he said he was not happy, they should have taken the chance, but Peggy replied that the appointment has been done and asked why he was bringing this up so late. That was the end of the conversation. She remembers that the actual procedure was scary but the staff was warm.

P: ....it was handled very professionally, I did get anxious, when I did get into the room, at that point I felt very anxious and asked if I could have a sedative, and at that point it was too late. You have to have it – and I do remember feeling resentful that I was more conscious than I wanted to be.
You know once they inject you there is no turning back, no matter how much you want to change your mind, it's done.

After the termination of pregnancy
After the procedure, Peggy remembers wanting to, “crawl into my bed, bury my head, and pretend this day never happened”. She talked about wishing she could call her friends to support her during this time, but she was afraid that they might judge her decision. The only person that knew at the time of the procedure was her husband and he did not want to talk about it. She said that even to this day she still thinks about the termination of pregnancy, and wonders what may have been different had she not terminated the pregnancy.
R: What did you predict OR what did you think your response would be?

P: Well, you know, I thought, it'd probably be on my mind for a couple of months. It's been two years. There are still times – and I can't tell you what triggers it, I really don't know – there'll be times when I'll be, you know, reading a book or drinking coffee or taking a walk or something, and I'll think to myself, “What if?” Or, “I wonder if it was a boy.” Or, “Maybe I should have been braver and taken a chance.” I still get very angry easily especially at my husband for many things, cheating, HIV, termination, blaming me, for his drinking and for not being available to me as his wife.

R:....What helps you cope?

P:....I read a lot and believe in the power of prayer. But lately it has been difficult as you know I have been diagnosed with clinical depression and am seeing a therapist.

Langa

Before the termination of pregnancy

Langa is a 31 year old teacher; she is not married and has 2 children. She was 22 years old and a grade 12 student at the time of her termination of pregnancy. She was about eight weeks along when she discovered the pregnancy. The termination of pregnancy was performed around week thirteen of gestation. Langa spoke about growing up in a family where sex before marriage was forbidden and termination of pregnancy was not even discussed. When she found out she was pregnant she stated that she was not in a stable relationship with her boyfriend at the time, and did not want to have a child alone.

The thought of terminating the baby came, she ran it by her boyfriend who did not object. She then concluded that termination of pregnancy would be appropriate. In making her decision, she focused on how a child would impact
her education as well as her relationship with her parents. She wanted to continue college uninterrupted and also felt that her parents would be angry and disappointed. More than anything she was clear that she did not want the consequences that would come along with a pregnancy.

**R:** Is there anything that kept you from exploring other options?

**L:** The other options would have been to have the child and keep it, have the child and give it to my mother to raise it as her own both these other options were obviously not going to work for me. Termination of pregnancy was what I needed to do.

**R:** You were then comfortable with that decision because you thought about the consequences that it would have on your family and your education?

**L:** Yes.

**During the termination of pregnancy**

Langa explained that she went alone to the termination of pregnancy clinic for the procedure and she was very nervous going in. She remembered that they explained to her in a group about the procedure, and answered any questions that arose. She said that the procedure was painful and she was nervous because they had neglected to give her a sedative. She recalled feeling that the woman who stayed with her during the procedure was very warm and caring, which eased some of her tension. She said that she recalls that the procedure was over rather quickly, and after she felt an overwhelming sense of relief.

**L:** I was very nervous. The woman that explained the physical steps of the procedure was a very warm and caring person which was helpful. We were a group of about 15. Some came with their boyfriends and some like me were alone.
R: How was the lady helpful?
L: .... She seemed warm and non-judgemental and mostly she seemed concerned.

After the termination of pregnancy
Langa explained that her experience at the clinic made it easier for her to deal with her feelings after the procedure. She said that she predicted that she would be relieved, and in the past eight years she has not had any regrets or negative feelings about having had the termination of pregnancy. She said that she examined her feelings about the termination of pregnancy very carefully during her pregnancies with both of her children, and they have not changed.
L: .... still today I feel that the decision to terminate was the best, I now can provide well for my two children. If I had kept the first baby and postponed college, I would not be where I am today. You know, I really feel like I made the right decision, and I really don't have any negative feelings or any regrets.

One of the coping mechanisms she described was a constant focus on her future, and committing herself to schoolwork and examinations. She did remember the counselor that was caring and held her hand during the procedure and checked on her afterward, which eased her stress. She told me that having her termination of pregnancy did not spoil her ability to enjoy her pregnancies or children when it was the right time for her. She would also caution women choosing termination of pregnancy to be careful with whom they share it, because she said having someone criticize her decision would have caused stress.

Gugu
Before the termination of pregnancy
Gugu is a 17 year 10 month old lady who had her termination of pregnancy when she was 15 years old. She is currently in grade twelve and is six months pregnant. Her Gynaecologist referred her to a psychologist for stress. She
remembered that when she terminated she found out that she was pregnant at eight weeks and terminated at 10 weeks.

She was dating her current boyfriend at the time, they were both still very young and she did not want to be embarrassed at school and in her community. Her boyfriend told her that he would marry her and they would have the baby, but he would support her in whatever decision she made. She grew up in an Anglican home. Her mother is a single parent who at the time was really struggling to make ends meet, as Gugu's older sister had just given birth as well.

When she found out she was pregnant, she knew she did not want the baby, not at her age. She consulted her mom, who tried really hard to sway her from the decision but to no avail. She gave up and offered to support her in any decision. Her boyfriend had told his family as well and also told them that she was considering termination. They were not happy and recommended that they get married and keep the baby. For Gugu that idea was out of the question. She felt she was fifteen, pregnant and now told to get married. The idea was incomprehensible.

She said she felt that having a child at that time would hold back her dreams and it would be a bad start for the child in that she was not able to provide for it. She said that she and her mother had dreams of her going to college; for her there was no other way but to terminate.

G: ....So I felt like it was the best decision that I could make at that time in the circumstances. And that's just how I dealt with it. I went in and I decided that this is what I wanted to do. And when I went to my Mom and sister, they kept saying, “Are you sure? Are you sure this is what you want to do? Are you sure?” And I was like, “Yes, I am.” And you know, what my mom's like, “You have to be like so sure that this is what you really want to do because, you know, once we start this whole thing, you can’t turn around and back out.”

Gugu explained that once she had made her decision, her mother made all the plans for her termination of pregnancy through their medical aid. Her boyfriend
and his family were not happy about the decision, they put pressure on him to convince her otherwise, which in turn put so much pressure on their relationship.

**During the termination of pregnancy**

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

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

G: When pregnant people tell you what it's like to give birth but nobody tells you what it's really like to terminate either because they have never done it or simply because they don't want people to know that they've done it. During the procedure, I was terrified. You don't know if they're doing stuff right, like when she was doing the needle, I kept thinking, "She is slicing my stomach open," because it hurt so bad as it was going through the muscles into the womb. It hurt so bad, I thought that she had actually taken like a hot knife and was – I mean I had like – I mean I stood up and looked because I was starting to freak out that she was ripping me open. I didn't understand why it hurt so bad.

G: And when you start dilating, they put something, I don't remember what she told me, something inside you, and also give you some drug that actually makes you go into labour. And then with that it starts dilating. And that was very painful. It was like having cramps like when you're on your period. You end up doubting if these doctors know what they are doing.

R: were you afraid?

G: Oh I was terrified. They did explain it to me what was going to happen but going through it, it felt like they had left out a whole chunk of information. So when it started, I felt "Oh, my God, do you know what you're doing? Is it supposed to hurt this much? Am I supposed to be feeling nauseous?"
After the termination of pregnancy
After the termination of pregnancy Gugu remembers that she felt really empty, this surprised her because she did not think she was going to be as upset as she was initially, and was not prepared for a depression period. She said that talking about it, praying, and crying all helped her to deal with her sadness. In the beginning her mom did not want her to see her boyfriend, guess she was still angry at him for not being supportive and also for impregnating her daughter.

Gugu reported that immediately after the termination of pregnancy she had this insatiable longing for the baby. She started to regret having had a termination of pregnancy. Her guilt was projected at her mom. She blamed her for not insisting that she keep the baby, stating that she is a child and her mother as an adult should have known better. She wished that somebody could have talked her out of it. Her boyfriend and his family were also angry at her for killing the child.

A year later she fell pregnant and is sure that she is going to keep this baby. The only problem is that her boyfriend is very distant with this pregnancy and doesn't want to bond with her. She is also afraid that God might punish her by taking this baby away. These thoughts are causing her so much stress that she has been admitted to hospital twice already.

G: .... I want to make sure that this baby gets everything she needs. I am going to love it and take good care of it although I am still young and I know my mother will be there for me.

R: .... Would you do it again?

G: .... Never ever again.

Nono

Before the termination of pregnancy
Nono is a 19 year old grade 11 student who had her termination of pregnancy when she was 17 years old. She discovered the pregnancy at eight weeks gestation and had the termination of pregnancy at twelve weeks. She grew up in a Christian family. At school she had an affair with a teacher and ended up falling
pregnant. When she discovered that she was pregnant she was confused and relied on her boyfriend for advice. He suggested that she terminate the pregnancy and he will take care of the finances. She did not want anyone to know about the pregnancy, especially her parents. She said she felt she needed to get out of the situation as soon as possible.

R: did you explore other options?
N: My boyfriend did not allow for any other option and I guess personally I did not want to know about other options as it made it easier for me to decide to terminate. Our main aim was to get rid of it and never to go through explaining the situation to the teachers, my parents and other students.

R: did you apply any strategies in making the decision?
N: Luckily for me I didn't have to make any decision my boyfriend did. I remember that I was just anxious and hoping that everything goes well as this had a potential to destroy his career as a teacher.

Nono's boyfriend made all the arrangements for termination. She relates that he was very supportive and loving and assuring during this time. It made it all bearable. She explained that deep down she knew it was against her religion and that if her parents found out about her pregnancy, let alone termination they would disown her.

During the termination of pregnancy
Nono does not remember anything about the actual procedure. She only remembers that her boyfriend was there with her, and therefore he is the one who can tell what really happened. The only thing she remembers was waking up and him telling her that it all went well and he was taking her home.

R: How do you think your boyfriend felt about termination of pregnancy?
N: Well his attitude was like, if you don't want it get rid of it. You are still young you can have as many children as you want in the future.
After the termination of pregnancy

Nono reports that after the procedure she was relieved but also felt guilty. This was the first time she had kept a secret from her parents, sisters and friends. She lived everyday after the procedure worrying if anyone might find out. Her boyfriend is still there for her, still in charge of everything including what type of contraceptive she should go on. She says she somehow feels lost and sometimes even questions herself, her beliefs and even existence. She feels out of control. She never spoke about termination of pregnancy with her boyfriend afterward but now and then she wishes they could talk about it as he is the only person who knows about it.

When asked how she has coped till now, she explained that she tries to socialise with her peers and goes to parties but she feels different from other teenagers and lately she spends most of her time at home sleeping. She has lost interest in everything.

R: ....If you had gone to counseling, what would you have considered as a successful outcome?
N:..... I probably would have still gone through with it but I think just making me talk about it and deal with it saying it out loud and actually dealing with it, instead of just going on, doing it. Could have made me feel less guilt.

R:..... would you do it again?
N:.....I really hope not

Names have been changed

One of the arguments against termination of pregnancy is that it causes severe depression and trauma to the mother. Termination of pregnancy opponents even claim that women may even suffer Post-Traumatic Stress Disorder – five, ten or even twenty years later. Pamphlets handed out by pro-life protesters at termination of pregnancy clinics usually start out with lines like “You are hurting.”
The experiences of these women are not to be trivialized; most struggle with the decision to have a termination of pregnancy, and most feel sorrow and regret. But the studies overwhelmingly refute the claim that these women go on to suffer severe trauma. The predominant response to termination of pregnancy is relief. This was confirmed by the study. The women interviewed said that at the time, their termination of pregnancy was the right thing to do.

With the subjects interviewed, only two women who are hurting in their ordinary lives decided to terminate their pregnancy, and link any later trauma to this experience, but it is clear that termination of pregnancy is not the primary source of their problems.

Part of the problem with the pro-life claim is that they are misusing the term Post-Traumatic Stress Disorder (PTSD). Inevitably, all people experience loss or trauma at some point in their lives. Normally, they go through a period of disorganization, after which the healing process begins. In a few years they may be back to normal. But in a small percentage of cases, the trauma is unusually severe, and the victims unusually susceptible. PTSD is a well-defined and extreme condition brought on by extreme circumstances, like war, concentration camps, brutal rape, disaster or torture. The symptoms are unmistakably severe: insomnia, anxiety, reliving the nightmare, withdrawal from society, emotional numbness, extreme passivity, even refusal to leave one's house. These symptoms usually settle in quickly, within weeks of the trauma, and without treatment usually last a lifetime. They do not lie dormant under the surface, to resurface five, ten, or fifteen years later (Ashton, 1980). If someone has PTSD, they will know it beyond all doubt. From the study subjects, no single one presented with PTSD symptoms.

However, the fact that the predominant response to termination of pregnancy is relief should not lull young women into believing that it is an easy form of birth control. It's actually the worst and most expensive form. There simply is no substitute for earlier and simpler forms of contraception.

Why relief?
As mentioned above, many women struggle with the decision to have a termination of pregnancy. All participants in this study related a sense of great relief when they had terminated their pregnancies, except for two participants who could not stop thinking every year that their children would be X years old now. Given the negative experience that termination of pregnancy undoubtedly is why is the predominant response to it relief?

One analogy is divorce. People may feel sorrow and pain due to divorce, but mostly they feel relieved to be getting out of a hellish marriage. Likewise, women who choose termination of pregnancy know it's the best of a bad lot of options. Expectant mothers instinctively know when conditions are not right for raising a child, and that going through with the pregnancy would result in needless suffering.

It was evident from the interviews that most women at risk of post-termination of pregnancy syndrome include women who feel pressured to choose termination of pregnancy in order to comply with the needs or wishes of others. This is especially true if the "wishes" of others are experienced as coercion, whether subtle or overt, such as threatening to withhold love or approval unless she "does the best thing."

Even lack of emotional support to keep a pregnancy may be experienced as a pressure "forcing" a woman to choose termination of pregnancy. In addition, pressure from adverse circumstances, such as financial problems, being unmarried, social problems, or health problems may also make a woman feel she is being "forced" to accept termination of pregnancy as her "only choice."

Mixed feelings about the termination of pregnancy

The second criterion for identifying high risk patients is the existence in the patient of any reluctance to have the termination of pregnancy. The source of her doubts may result from either conflicting moral views about termination of pregnancy, or from a conflicting desire to keep the baby.
Eighty percent of the study subjects related that they have a negative moral view of termination of pregnancy.

The vast majority of aborted women, therefore, can be classified as "soft core" abutters for whom termination of pregnancy was a marginal choice which they would not have pursued if it had been illegal.

The ambivalence which the majority of women feel with regard to the morality of termination of pregnancy is compounded by the ambivalence which many feel about keeping the baby. From the study interviews some of the participants expressed that at some stage they had some desire to keep the child. The two participants, who were undergoing therapy for post termination of pregnancy trauma, relate that they had gone to the clinic still hoping for a "miracle" option which would have allowed them to avoid the termination of pregnancy and to keep the baby.

It is noteworthy that the two criteria for high risk termination of pregnancy patients -- feelings of being under pressure to terminate and feelings of ambivalence -- are typical of women who terminate for reasons of physical health, psychological health, fatal malformation, rape or incest.

Indeed, when viewed within the frame work of high-risk criteria, all of the categories typically associated with "hard case" termination of pregnancy are actually contra-indicated for termination of pregnancy. While there are many reasons for this, a simplified explanation is that the harder the circumstances which a pregnant woman faces, the more she feels "forced" into a decision which is not freely her own.

**Feelings of self-betrayal**

In light of the above evidence, the psychological impact on high-risk termination of pregnancy patients is quite understandable. In the vast majority of cases, women seeking termination of pregnancy feel under intense pressure to do so. Yet at the same time they experience moral qualms about the termination of pregnancy itself, and/or they feel maternal desires to protect their pregnancies.
Therefore, for these women, termination of pregnancy is not a glorious right by which they are able to reclaim control of their lives; instead it is an "evil necessity" to which they submit because they "have no choice." The Natural Law Ethical Theory argues that it is human nature to feel like this, regardless of culture, religion or background.

Rather than affirming their own values, these women feel forced to compromise their values. Rather than feeling proud of themselves for standing up against difficult situations, they feel ashamed of themselves for being "spineless cowards."

This feeling of self-betrayal is a devastating blow to the woman's self-image and her feelings of self-worth. She is internally divided by an emotional "war" within and against herself. On one side are her original moral beliefs and maternal desires. On the other side is her termination of pregnancy experience which represents a choice to act against those feelings. These two sides of herself are irreconcilable. The unresolved feelings which arise from this internal warfare can manifest themselves as a wide variety of psychological illnesses.

**Low risk termination of pregnancy patients**

In contrast to the high-risk termination of pregnancy patients, the women who appear to be least at risk are those for whom termination of pregnancy is a free choice which they make under little or no pressure. In addition, such women would have no moral qualms about termination of pregnancy and would have little or no interest in having children.

Because they truly see termination of pregnancy as "good," these women can be categorized as "hard core" abutters because they are more likely to pursue a termination of pregnancy even if it were illegal.

In contrast, high-risk patients are generally "soft core" abutters because they are looking for ways, or even excuses, to avoid their unwanted termination of pregnancy. These women are very unlikely to pursue an illegal termination of pregnancy unless coerced into by others.
What women suffer

The common theme in most of the interviews was relief after termination of pregnancy (one of the few positive emotions). This emotion is understandable, especially in light of the high degree of pressure terminating women feel to "get it over with."

Temporary feelings of relief are frequently followed by a period that psychologists identify as emotional "paralysis," or post-termination of pregnancy "numbness." Like shell-shocked soldiers, these aborted women are unable to express or even feel their own emotions. Their focus is primarily on having survived the ordeal, and they may be, at least temporarily, out of touch with their feelings.

Thirty to fifty percent of aborted women report experiencing sexual dysfunctions, of a temporary or permanent nature, which appear immediately after their termination of pregnancy. These problems may include one or more of the following: loss of pleasure from intercourse, increased pain, an aversion to sex and/or males in general, or the development of a promiscuous lifestyle. (Corney:1990)

Up to thirty three percent of aborted women develop an intense longing to become pregnant again in order to "make up" for the lost pregnancy, with eighteen percent succeeding within one year of the termination of pregnancy (Corney, 1990). One of the participants interviewed who had had termination of pregnancy when she was fifteen was pregnant again and she is seventeen, at school and is going to keep the child. Unfortunately, many women who succeed at obtaining their "wanted" replacement pregnancies discover that the same problems which pressured them into having their first termination of pregnancy still exist, and so they end up feeling "forced" into termination of pregnancy the second time as well.

Denial of reality

While many high-risk women will begin experiencing negative emotional and behavioural patterns soon after their termination of pregnancy, these problems
are frequently blamed on people, situations, or circumstances other than the termination of pregnancy. This is typical occur during a period of denial which commonly follows a traumatic termination of pregnancy experience (Corney, 1990).

During this time, the high-risk woman may go to great lengths to avoid people, situations, or events which she associates with her termination of pregnancy. She may even become vocally defensive of termination of pregnancy in order to convince others, and mostly herself, that she made the right choice and is satisfied with the outcome. But later, when seeking counseling for seemingly unrelated reasons, this woman may discover that her psychological difficulties stem from a traumatic termination of pregnancy which she had repressed. (Corney: 1990)

Repressed feelings can result in psychological and behavioural difficulties which exhibit themselves in unpredictable ways. One example of seemingly unrelated problems can stem from repressed feelings is found in the increased occurrence of eating disorders such as anorexia nervosa and bulimia among aborted women. In some cases, counseling for a traumatic termination of pregnancy experience can lead to a dramatic recovery from anorexia nervosa.

Denial and repression may last for years, or even decades, until some event finally triggers a "crisis" which forces a woman to confront her unresolved feelings. Numerous researchers have reported that post-termination of pregnancy crises are often precipitated on the anniversary date of the termination of pregnancy or the unachieved "due date." Reproductive experiences such as the birth of a later child, miscarriage, or unsuccessful attempts to get pregnant, are also frequently associated with precipitating a delayed post-termination of pregnancy crisis. Some women, who would otherwise appear to have been satisfied with their termination of pregnancy experience, are reported to enter into emotional crisis decades later with the onset of menopause or after their youngest child leaves home (Teng; 1999).
Self destructive behaviour

Women who have undergone post-termination of pregnancy counseling report over 100 major reactions to termination of pregnancy. Among the most frequently reported are: depression, loss of self-esteem, self-destructive behaviour, sleep disorders, memory loss, sexual dysfunction, chronic problems with relationships, dramatic personality changes, anxiety attacks, guilt and remorse, difficulty grieving, increased tendency toward violence, chronic crying, difficulty concentrating, flashbacks, loss of interest in previously enjoyed activities and people, and difficulty bonding with later children. (Reardon, 1998).
CHAPTER 5
Conclusion and recommendations

Not much research has been done to elicit the experiences of women who undergo termination of pregnancy in South Africa. This study begins to fill that void by describing the entire termination of pregnancy process, including coping and constraints on coping efforts, as well as resources for six women who participated in the study.

The participants were recruited through word of mouth. They were asked about their experiences from the time they discovered the pregnancy to the present. They were also asked about family beliefs and relevant background information. The participants shared the information pertaining to the questions asked and any other information they believed was relevant for them.

Many commonalities and themes emerged among the participants’ interviews. All of the participants, in making the decision to terminate pregnancy, weighed up the pregnancy as stressful. They all saw the pregnancy as a threat to either their future plans or relationships with family. All of the women believed before the termination of pregnancy that it would be a short-term stressor, and that it would have little, if any, effect on their lives.

For all the participants except one, this has not been the case, and they described it to be much more profound and more the cause of long-term stress than they had believed. All of the women described using some form of avoidance as a form of coping and many described sharing their experience with others. The resources the women described included their family, friends, and physician. Personal constraints were most often described as internalised pro-life values from their family of origin. Environmental constraints in all cases were that they were not given enough information, not only about the procedure itself, but also about longer term emotional effects.
Implications
The information gained in this study was obviously important to the participants because all of them expressed an interest in reading the findings of the research once it was completed. It may be helpful to women who have had a termination of pregnancy to read other’s experiences to see that they are not alone in their experiences and feelings.

Finding commonalities through reading other’s stories may be similar to one of the ways that many women coped by sharing their experience with others. In addition to women who have already had termination of pregnancy, women contemplating termination of pregnancy may also find the research helpful to see what experiences others who have chosen termination of pregnancy have had.

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

This research might also assist mental health clinicians to understand the experiences of women undergoing a termination of pregnancy. Although I have not yet had the opportunity to work with a client who has had or is considering termination of pregnancy, I would definitely share my findings with them to give them a range of the women’s experiences. If I felt that it was appropriate, I would also allow them to read my thesis so they could get a more detailed description of the findings, so that they could hear the voices of the participants. In reading what the women said in their interviews, it would also be helpful to understand that they felt supported by supportive persons.
This study will hopefully assist clinicians, or anyone else helping a woman through the termination of pregnancy process, understands her needs, so that the woman would be more likely to talk about their experiences freely.

As a clinician myself, this research has greatly affected the way I think about termination of pregnancy, as well as how I would work with a woman who has had an termination of pregnancy. I must admit that when I decided on the subject for my research topic, I did not believe I was fully cognisant of the political nature of the subject matter until several colleagues responded with comments about how brave I was to research the topic on termination of pregnancy.

In South Africa we live in a new political dispensation where everything one says has to be politically correct, therefore using the word abortion was frowned upon by many people I spoke to, advising me to rather use the term termination of pregnancy as it so referred to in our constitution and South African policies. Although I thought I was very comfortable with the topic, classifying myself as non-judgmental, but pro-choice, I must admit I found myself a little anxious telling those I did not know well about my research topic.

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

**Limitations**

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

Lack of random sampling, control group, and voluntary participation limit the generalizability of these findings. The previous limitations are, of course, limitations of the majority of qualitative research, since it is designed to give a greater depth of individual's unique experiences. This population of women is difficult to reach, and was therefore limited to those who would respond to an invitation and were willing to participate in this study, post to being referred by other professionals to talk about their experiences. This study was not expected to be generalizable to all women who have had termination of pregnancy. It did however attempt to develop an understanding of the experiences of those women who participated in my study.

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

Another limitation was the subject matter itself. Due to the strong societal beliefs surrounding termination of pregnancy, the literature itself shows a strong discrepancy in its findings, which may possibly be due to differing agendas. Little research states any biases of the researchers, so it is difficult to determine what literature should be given more merit. Due to this my research is based on literature with a broad range of findings, which may be subject to the researcher's belief systems.
**Future Research**

The goal of this research was to get an overall picture of the entire process the women went through. Since only the women were interviewed, the research could be expanded to include the process from the viewpoint of the women's partner, resources, clinic staff, and families. Anyone who had a part in helping the woman through the process could be investigated to see their viewpoints on the process. Their perspectives could also be compared with the women obtaining the termination of pregnancy. Another sample of women who considered termination of pregnancy, but chose to keep the pregnancy could also be investigated to see how their processes varied from the women who chose to terminate.

**Conclusion**

The goal of this research was to understand more about the entire process women go through in the decision to have a termination of pregnancy and how it affects them. Each of the participants shared in great depth their unique experiences and perspectives on a stressful life event. Although there were many common points among their individual stories, each of them had a unique perspective. The results leave me feeling hopeful about the resiliency of these women, because although all of them described some part of the experience as stressful, they have all found ways to cope with their termination of pregnancy.
References


APPENDIX A

Participant's Informed Consent

Title of the Study: Phenomenological investigation into the experiences of therapeutic termination of pregnancy

Investigator:
This study is being conducted by Nokuthula Eunice Dlamini, candidate for a master's degree in Clinical Psychology at the University of Zululand.

I. Study Purpose
The purpose of this study is to understand the experiences of therapeutic termination of pregnancy and the importance of pre and post termination of pregnancy counseling.

II. What Will I Have to Do?
- Fill out Informed Consent and a demographic information sheet.
- Participate in an interview and answer questions about your termination of pregnancy experience.
- Write down your termination of pregnancy and counseling experience.
- The interview will take about two hours.

III. Benefits of this Project
- You will be helping others who have had termination of pregnancy as well as clinicians to understand the important aspects of the decision-making and coping processes.
- Hopefully, the findings will be helpful to those making a decision or who have had a termination of pregnancy and clinicians in working with female clients where termination of pregnancy is an issue.
IV. Is it Private?

- The information you share will be treated as completely confidential.
- Only the researcher/interviewer and her faculty advisors will have access to the information you share.
- Your name will be removed from the answer sheet,
- Your name will not be used in any documents produced as a result of this study. Every effort will be made to change any information that might allow someone to identify you.
- At the completion of this study, all raw data that has been collected will be destroyed.
- If you share information that leads the researcher to believe you are in danger of doing harm to yourself or someone else, the researcher must take steps to protect you or others.

V. Risks

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

VI. Compensation

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

VII. Freedom to Withdraw

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

- I have read and understand what my participation in this study consists of. I know of no reason that I cannot participate in this study. I have had all my questions answered and hereby give my voluntary consent for participation in this project.

- If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

- Should I have questions about this research I will contact: Nokuthula Dlamini (082 836 8299)

______________________________  ________________________
Participant's Signature        Date
APPENDIX B

Demographic Questionnaire

1. Current Age ______
2. Age when termination of pregnancy occurred ______
3. Approximate length of pregnancy when you found out you were pregnant ______
4. Approximate length of pregnancy when termination of pregnancy occurred ______
5. Were you married or had children when you experienced the termination of pregnancy?
6. Are you currently married? Number of children ______
7. Your ethnicity: Coloured, African, Asian, White ______
8. Current religion _____________ Religion at the time of the termination of pregnancy ______
9. Highest degree of education at present ______________________
10. Degree of education at time of termination of pregnancy ____________
APPENDIX C

Questions for Interview

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

1. How did you decide what options were available to you in making the decision to abort?

2. What, if anything, kept you from exploring alternate options?

3. What strategies did you apply to make the decision? Did they change over time? How?

4. At the time prior to the decision-making what were your beliefs about termination of pregnancy? What were your family's/friend's/society ideas about termination of pregnancy?

5. How confident did you feel that you could control how much the termination of pregnancy impacted your life?

6. What did you predict would be your response to the termination of pregnancy?

7. What emotions did you encounter in making the decision, during the procedure, and afterward? Did they change? When?
8. If you experienced any emotions what did you consider your resources to help deal with them (e.g. counseling)? If you did not seek out any resources, what kept you from doing so?

9. How would you rate your level of stress before, after, and during the procedure? If any level of stress changed to what would you attribute this change?

10. What do you think may be the difference between someone who experiences termination of pregnancy as stressful versus someone who does not?

11. What helped you to cope/adjust/make it through a stressful time?

12. Overall, how would you assess or rate your abilities to cope?

13. Would you do it again?