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Graduate School

POST-ABORTION COUNSELING AND ANXIETY LEVELS OF UNMARRIED ADOLESCENTS HAVING THERAPEUTIC ABORTIONS

by

Linda Levisen

A Thesis in Partial Fulfillment

of the Requirements for the Degree

Master of Science in the Field of Nursing

June, 1972

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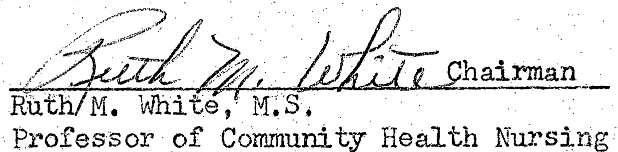
Each person whose signature appears below certifies that he has read this thesis and that in his opinion it is adequate, in scope and quality, as a thesis for the degree of Master of Science.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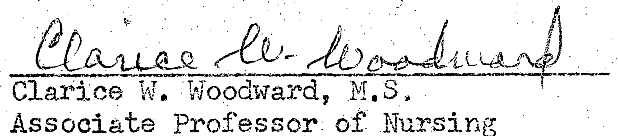
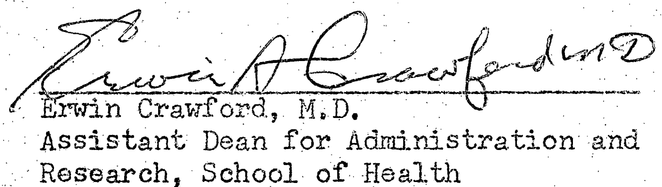


Clarice W. Woodward, M.S.
Associate Professor of Nursing



Erwin Crawford, M.D.
Assistant Dean for Administration and Research, School of Health

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CHAPTER I

FORMULATION AND DEFINITION OF THE PROBLEM

INTRODUCTION

With the recent legislative action liberalizing abortions there is a rising number of women who are seeking and getting legal abortions. A significant number of these are among unmarried adolescents (State of California Department of Public Health, 1970). A period of disorganization usually occurs. The adolescent's emotional equilibrium or balance is upset, and in trying to resolve this disequilibrium many turn to abortion as the adaptive resolution of the crisis.

Studies have shown that although there is symptomatic relief of the unwanted pregnancy, there is some degree of guilt and transient depressive reactions. There is a sense of loss which almost invariably exists immediately following an abortion (West, 1970, p. 1923). Very little research has been done to determine if nursing intervention following the abortion could reduce the negative affects which are sometimes experienced. In giving crisis intervention through post-abortion counseling, the community health nurse would be assisting the individual in regaining a pre-crisis level of functioning and also decrease the tragedy of subsequent unwanted pregnancies.

Statement of the Problem

What can be done to reduce anxiety, depression, hostility, and

guilt which the unmarried adolescent may feel during the immediate post-abortal period? Can nursing intervention reduce these negative affects and help the person make a healthy adjustment to the crisis of abortion?

Need for the Study

Currently, as well as in the future, health professionals will have new responsibilities for providing safe abortion services (Tyler and Schneider, 1971, p. 491). Emphasis has been placed on appropriate information to aid the adolescent in making her decision to have an abortion, and in providing her with adequate referrals to reputable doctors who will perform legal abortions. Little attention has been given to the need for post-abortion evaluation and counseling. David (1971) feels there is a great need to identify behavior patterns of women who are at risk for repeated abortions, and to identify those most likely to require psychological attention following the abortion (p. 510).

Subsequent unwanted pregnancies following an abortion constitute a continued public health problem of growing enormity. Community health nurses are looking for ways to prevent this recidivism, especially among unmarried adolescents. Abortion may prove to be the best of alternatives available to the girl, but the factors that were involved in the first unwanted pregnancy must be understood and resolved in order to prevent a second unwanted pregnancy.

A study conducted by Marder, et al. (1970b) has shown that most patients wished reassurance and support after the abortion (p. 660). If community health nurses establish a therapeutic relationship with the girl following the abortion, it may be that psychological equilibrium and self-esteem can be achieved for this adolescent. Psychological sequelae and possible long-term ill effects of an abortion may be

minimized, thus enabling the girl to make a more healthy adjustment to the crisis.

Purpose of the Study

The purpose of this study was to evaluate the effectiveness of a post-abortion counseling program for unmarried adolescents in reducing negative affects which the adolescent may exhibit or feel immediately following the abortion.

Hypothesis

Unmarried adolescent girls who receive post-abortion counseling will exhibit significantly fewer negative affects than those adolescents who receive no counseling.

Definition of Terms

For the purpose of this study the following terms or words are described:

Therapeutic Abortion: Removal of the products of conception by dilatation and suction currettage of the uterus for psychiatric reasons which indicate that continuing the pregnancy might be detrimental to the mental health of the mother.

Unmarried Adolescent: A girl between the ages of 16-21 years who has not as yet entered into a licensed marriage contract.

Post-abortion Counseling: Short-term therapy designed to reduce the impact of the unwanted pregnancy, the abortion experience, and the person's increased anxieties related to this crisis.

Negative Affects: Negative feeling-responses such as anxiety, depression, hostility, or guilt to a particular object, experience, or idea (Howard,

et al., 1969, p. 616; English and English, 1958, p. 15).

Limitations

1. Evaluation of short-term negative affects were limited to two weeks after the abortion.

2. The study concerned only those adolescent girls who gave their permission for follow-up.

3. The testing tool used to measure guilt was patterned after the Likert Scale, but was not standardized.

Assumptions

The following assumptions were made in this study:

1. That the adolescent girl who requests an abortion has by her own choice decided to terminate the pregnancy by a legal abortion.

2. That the adolescent girls involved in this study did not receive additional information or counseling prior to the abortion which would significantly alter the emotional affects.

3. That the tests given to the clients were accurate measuring tools of their psychological response to the abortion.

METHOD OF STUDY

The experimental design was used in this study. This permitted the researcher to manipulate certain variables in order to effect change. A post-abortion counseling program was given to the experimental group immediately following the abortion to determine if the counseling would decrease the negative affect responses to the crisis of abortion (Sax, 1968, pp. 335-336).

SCOPE OF STUDY

Selection of the Facility

The San Bernardino County Health Department serves the health needs of an estimated population of 715,000 people. Besides the main division located in the city of San Bernardino, the County maintains seven other branch health centers throughout the county. One of the health department's valuable services is Family Planning. Counseling and clinic services are available without charge to anyone who wishes this service. Counseling regarding problem pregnancies was begun in 1970 as an expanding branch of the Family Planning Service. The Health Department refers to a "problem pregnancy" as any non-planned, unwanted pregnancy which threatens the person's life-style and her ability to cope with the crisis of an unwanted pregnancy.

As the result of the liberalized California abortion law of 1967, many girls are seeking therapeutic abortions as the means of terminating an unwanted pregnancy. It is the responsibility of the health department to provide adequate medical advice and appropriate referrals to recognized medical facilities where legal abortions can be obtained. The Director of Family Planning Services of San Bernardino County reports that approximately 100-150 women per month request counseling for a problem pregnancy. Of these, 50-60% actually obtain legal abortions. Exact statistics are not available as this is a relatively new program. At the present time there has been very little follow-up of these women.

Because of the convenience and accessibility of clients, the central office of the San Bernardino County Health Department was chosen as the facility in which to conduct this study. Interviews with clients

were conducted in the Bureau of Public Health Nursing.

Selection of the Sample

The population for this research were those unmarried adolescent girls who requested therapeutic abortions for psychiatric reasons. A convenience sample was selected from those adolescents who came to the San Bernardino County Health Department requesting therapeutic abortions. A total of approximately 125-150 women were counseled regarding a therapeutic abortion by the researcher during the time that the sample for this study was selected. It was noted that there was considerable divergence in attitudes toward a therapeutic abortion as expressed by the different groups of women. The married women reacted quite differently and with less ambivalence to the abortion than did the single girl. The adult single girl seemed more mature and accepting of her decision to have an abortion than did the single adolescent. Because of these variations in the responses to a therapeutic abortion, it was felt that a more factual research study could be made if the sample was selected according to the following criteria:

1. That the client be unmarried with no history of a previous pregnancy;

2. That she be at least 16, but no older than 21 years of age; Crow and Crow (1956) feel that the period of adolescence does extend to age 21 (p. 4).

3. That there is no history of psychiatric therapy or evidence of mental retardation;

4. That the request for abortion was not due to incest or rape;

5. That the abortion would be performed before the twelfth week

of pregnancy. Reports indicate that patients who were aborted by amnio-infusion showed more guilt and depression than those who had dilatation and currettage (Marder, 1970b, p. 660).

6. That the client be able to converse in English.

The sample was divided into an Experimental and a Control group. The first client accepted for the study after meeting the above criteria was placed in the Experimental group. Each subsequent client accepted was placed alternately in either the Experimental or Control group. A total number of twenty-eight clients were selected for the study. Because eight clients were excluded from the study, a total of twenty clients completed the research program. Ten clients were in the Experimental group, and ten were in the Control group.

METHODOLOGY

Selection and Development of Tools

Marvin Zuckerman and Bernard Lubin's Multiple Affect Adjective Check List (MAACL) was the tool chosen to "provide valid measures of three of the clinically relevant negative affects: Anxiety, Depression, and Hostility" (Zuckerman and Lubin, 1965, p. 3). Development of this test was first begun in 1960 when Zuckerman empirically developed a scoring key for anxiety (Zuckerman, 1960, p. 457). It was later realized that the development of two new scales for depression and hostility were needed. In combining these three check lists for measuring anxiety, depression, and hostility into one test, this extended scale is now called the MAACL (Zuckerman, *et al.*, 1964, p. 418). (See Appendix A)

The test was designed to measure changes in anxiety over shorter periods of time as well as a generalized level of anxiety. Therefore

two forms of the test were developed: a "General" form and a "Today" form. Both forms contain the same list of adjectives but the former has instructions for the subject to check the words that describes how he "Generally" feels while the latter has instructions describing how he feels right now or "Today." The researcher chose to use the "Today" form since the clients were asked to describe how they feel or react today to the crisis of an unplanned pregnancy and abortion.

A test was needed for this study which would be brief, simple, and quick to complete. The MAACL met these requirements. It requires only 5-10 minutes to complete, is self-administered, and all the words are at or below an eighth grade reading level.

The test is comprised of a total of 132 adjectives: 21 items measuring anxiety; 40 items measuring depression; and 28 items measuring hostility. The additional items are used as "fill-in" words to prevent the subjects from recognizing the true intent of the test (Zuckerman and Lubin, 1965, p. 4).

The MAACL has been tested and shows positive correlations with some of the frequently used tests for anxiety, depression, and hostility (Zuckerman and Lubin, 1965, pp. 313-316). Bloom and Brady (1968) report the test to be highly reliable and valid (p. 45).

A review of literature regarding psychological tests showed no simple concise test for guilt. Therefore the researcher developed an attitude scale measuring guilt. (Appendix B) Construction of the scale was patterned after Likert. A Likert-type scale calls for a graded response to each statement or word. The response is usually expressed in terms of five specific categories. The client was asked to respond to adjectives describing guilt by checking one of the following five

categories: Not at all; Very little; Some; Quite a bit; Very much. To score the scale, the alternative responses are credited 5,4,3,2,1, respectively, from the favorable to the unfavorable end. The sum of the item credits represents the individual's total score (Anastasi, 1961, p. 551).

Although this test measuring guilt was not standardized, it was hoped that it would reveal presense or absence of guilt. Since there was both a pre and a post test given, each client served as his own control.

Selection of Nursing Intervention

An unmarried adolescent who has just had a therapeutic abortion may be in a very real crisis and may not have effective coping mechanisms to resolve her feelings of anxiety, depression, hostility, and/or guilt. Nurses have a unique opportunity to respond to individuals in crisis. Because of her skills and experience in dealing with emergencies, the prepared community health nurse is in a position to practice crisis intervention (Morley, et al., 1967, p. 553). When working with adolescents who are seeking abortions, the prepared community health nurse may be able to assist the adolescent in regaining effective coping patterns for a healthy adjustment to the abortion.

Caplan (1961) defines a crisis as "an upset in a steady state" (p. 18). This concept of crisis is built upon the theory that under normal circumstances, a person is able to maintain a state of equilibrium by using a repertoire of effective coping mechanisms. But in a state of crisis these problem-solving activities do not work, which leads to a state of disequilibrium. A crisis is often recognized by

observable signs of anxiety, depression, anger, shame, and guilt. It also has certain characteristics: It is usually self-limiting; goes through the phases of impact, recoil, and post trauma, and is usually resolved by problem solving, re-definition, or denial (Bindman and Spiegel, 1969, p. 428).

Crisis intervention is a unique form of treatment adapted to a critical situation that has caused the disturbed equilibrium. It's two-fold objectives are: 1. "reducing the impact of the crisis, and, 2. helping the person develop behavioral responses that will effectively cope with the current and succeeding crisis" (Matheney, 1970, p. 322). Hopefully, crisis intervention will help the person avoid maladaptive ways of resolving crisis such as the use of denial.

Nursing intervention for the post-abortion counseling program used in this research study involved the technique of crisis intervention. The counseling program was implemented through the following sequence of steps (Auilera, Messick and Farrell, 1970, pp. 16-17):

1. Assessment of the adolescent and her problem.
2. Planning therapeutic intervention.
3. Intervention:
   A. Helping the adolescent gain an intellectual understanding of the crisis.
   B. Helping the adolescent recognize and accept her present feeling about the abortion which she may have been denying to herself.
   C. Exploration of the adolescent's coping mechanisms.
   D. Reopening the social world to the adolescent.

4. Helping the adolescent resolve the crisis and assist in anticipatory planning. (See Appendix C for complete nursing intervention guide.

Management of the crisis means that the nurse must keep a channel of communication open; she must encourage the adolescent's questions and attempt to answer them; she must be supportive to the adolescent during the experience of loss and the grieving process (Senay, 1970, p. 414). Especially is this true when working with unmarried adolescents who have very recently had a therapeutic abortion. They are often so ashamed and fearful that the nurse may be judgmental that they attempt to hide their feelings, or are so embarrassed that they are not able to ask meaningful questions. This is when the prepared, skilled nurse must be ingenious in using her counseling skills to assist the adolescent in bringing out her feelings and discussing them in a therapeutic manner. Often the nurse's skills of listening, patience, honesty, nonjudgmental manner, and caring about each adolescent as an individual will do much in reducing negative emotional disturbance (Burknardt, 1969, p. 2153).

The Pilot Study

A pilot study was done to: refine the testing tools that were chosen for this study; test the efficiency of the method for collecting the data; and determine if any changes were needed in the nursing intervention. Two clients were selected for this preliminary study; one being in the experimental and one in the control group. As a result of this study, the researcher felt that a questionnaire depicting the client's general attitudes on abortion as a legal and moral issue would be of value.

The questionnaire which was selected consisted of eight short vignettes or statements dealing with abortion. These statements were part of a large questionnaire which was used in San Francisco by a team of medical workers who maintained a clinic for problem pregnancies (Gabrielson, et al., 1971). (Appendix D) After completing the pilot study no further changes were made in the test materials or nursing intervention used in the remainder of the research study.

THE COLLECTION OF THE DATA

The Process of Obtaining Clients

Between June, 1971, and November, 1971, a selected sample of twenty-eight clients were chosen for this research study. Eight of these clients had to be excluded for certain reasons: Three clients were lost to follow-up due to false names, addresses, or moving to an unknown address; one client decided to marry and keep the baby; one client repeatedly failed follow-up appointments and finally refused further follow-up; one client refused follow-up after the abortion stating, "I am too upset to talk about it," and, "I wish I'd never had the abortion. I wish I'd kept the baby." One client waited too long to have the abortion before the twelfth week and finally had to have a saline-infusion type of abortion; one client had the abortion but failed to notify the researcher until it was too late for counseling follow-up.

After a positive verification of pregnancy and the decision to terminate the pregnancy by a therapeutic abortion, the clients were seen by the researcher for pre-abortion counseling and referral. A Pregnancy Referral form giving general information concerning the patient was completed by the researcher. (Appendix E) No difference was made in the pre-abortion counseling for the Experimental and the Control

groups. The researcher discussed the following with each client:

1. Therapeutic abortions are legal in California.
2. Anatomy and physiology of the female reproductive system.
3. The medical procedure of the abortion.
4. The client's attitude toward the abortion.
5. Parental attitudes and feelings.
6. Need for a method of birth control following the abortion.

Each client was given a list of three physicians who perform legal abortions in the surrounding area. It was explained to her that she was responsible for contacting one of the doctors or clinics for an appointment regarding the abortion.

Data Collection

At the end of the pre-abortion counseling session, the client was informed of the researcher's study and asked to participate. Each client was asked to give her written consent. (Appendix F) She was then given two tests: 1) The MAACL test which is a standardized test to measure the negative affects of anxiety, depression, and hostility, and 2) A Likert-type scale measuring guilt.

Experimental Group. The researcher made an arrangement with each client in the experimental group to visit twice following the abortion. The client was told that the purpose of the visits was to talk with her about her physical condition and the abortion experience. After notification from the client of her abortion, the researcher made the first visit 2-3 days after the abortion. At the visit, before nursing intervention was given, the client was again given the same two tests as previously taken during the pre-abortion counseling session. The

second post-abortion counseling visit was made 7-14 days following the first visit. Nursing intervention was given, after which the client again completed the two tests previously taken. In addition, the client also completed the questionnaire regarding general attitudes on abortion. (Appendix D)

Control Group. Each client in the Control group was informed that the researcher would make two appointments with the client following her abortion. The client was told that the purpose of the visits was to just complete the same two tests as taken during the pre-abortion counseling session. The clients were also told that each visit would take only 5-10 minutes of their time. As with the Experimental group, after notification from the client of her abortion, the researcher made the first visit 2-3 days after the abortion. The second visit was made 7-14 days following the first visit. At both visits, the two tests: the MAACL and the Likert-scale for measuring guilt, were administered to the clients. At the end of the second visit, the client was requested to complete the questionnaire regarding general attitudes on abortion. Although the researcher did have some contact with the clients after the abortion to administer the tests, no nursing intervention was given and there was no discussion of the abortion experience. With both the Experimental and the Control groups, the post-abortion visits were made at the client's home or at a place of her choice.

Analysis of the Data

Analysis of the data was done by using the t test statistic to determine the difference between the two samples. Percentage comparisons were used to evaluate the results of the questionnaire on abortion attitudes.

CHAPTER II

THE REVIEW OF THE LITERATURE

INTRODUCTION

Legal abortions performed in the United States are rapidly increasing. In California 60% of these abortions are being requested by unmarried women under 25 years. In this review, the following areas will be discussed: 1. The crisis of adolescent illegitimate pregnancies and abortions, 2. The psychological sequelae of anxiety, depression, hostility, and guilt which may follow the abortion, 3. Adolescent attitudes toward abortions, and 4. The need for post-abortion counseling in reducing negative affects and in assisting the adolescent in regaining emotional equilibrium.

INCIDENCE AND PROBLEMS OF ADOLESCENT ILLEGITIMATE PREGNANCIES

As the rate of out-of-wedlock births continue to climb, associated health and social hazards threaten teenage unwed mothers in the nation. They become problems of major community health significance. It is impossible to provide accurate statistics for the number of adolescent illegitimate pregnancies which occur each year within the United States. The number is certainly higher than is generally assumed by the public. In the United States the number of illegitimate births per 1,000 unmarried women in the reproductive ages has tripled since 1940 (Clague

and Ventura, 1970, p. 2). Although current statistics are not available for verification, Guttmacher estimated that for the year 1970 at least 300,000 illegitimate children would be born in the United States. Approximately 72,000, or about 25% of these births would occur to adolescent girls under the age of 18 years (Guttmacher, 1970, p. 1).

For California, the most recent statistics of illegitimate births are taken from the Bureau of Vital Statistics for the year 1966-1967. Approximately 337,000 live births were registered to California women each year in 1966 and 1967. Among these births 9.4% were classified as apparently illegitimate in 1966; and 10.5% in 1967. This indicates that the problem of illegitimate births is significantly increasing in California (State of California Department of Public Health, 1971, p. 10).

These statistics in no way account for the vast number of unwanted pregnancies which are either terminated by a therapeutic abortion or become legitimate through marriage. Current reports show that up to one-fifth of all pregnancies ending in a live birth are not wanted (Bumpass and Westoff, 1970, p. 1177).

The multi-factors causing adolescent girls to become pregnant out-of-wedlock continues to be a significant medical, social, and moral problem. Authorities in the medical and social fields are still seeking possible solutions. Vincent feels that "the psychological variations of unwed mothers run the gamut of human characteristics, and there is no particular personality profile that is characteristic" (Vincent, 1961, p. 179). However, other noted authorities argue this point. Waters (1969) and his staff have identified a definite "syndrome of failure" in pregnant adolescents (p. 655). A study conducted by Kinch, *et al.* (1969) revealed that the phenomenon of illegitimate pregnancies no

longer belong to the "stereo-type of low socio-economic, low-mentality, and promiscuity" (p. 27). Younger adolescents and those from elite social classes are also faced with the crisis of an unwanted pregnancy. And in most cases the girl had only one sexual partner.

Young (1954), who has spent many years working with unwed mothers, finds that adolescents experience many psychological problems which the older unmarried mothers have already passed through. Augmented by the onset of puberty, adolescence often becomes a state of confusion, emotional stress, and violence. An unwanted pregnancy occuring for the adolescent is an expression of these conflicts. An out-of-wedlock pregnancy does not just "happen," there is a reason--a chain of cause and effect. In every case which Young observed, the girl expressed unhappiness and problems in her life which led to this action (p. 94). West (1970) supports this observation by assuming that in this day of the "pill" and numerous other methods of contraception anyone who gets pregnant has some conscious or unconscious reason for getting pregnant if there has not been a contraceptive failure or forcible rape (p. 1925).

In observing unmarried pregnant adolescents, Kimball (1970) found that these girls reflected feelings of anomie, apathy, and depression. The pregnancy was viewed as "an attempt to change things, draw attention to oneself, create some ripple in a dissolute environment." It was also a way of demonstrating independence (p. 294).

In most cases, the unwed pregnant adolescent is very lonely, and may frequently use sexual relations to help escape from an emotionaly sterile life. Relationships with her family are often poor, with the pattern of domination by one parent, usually the mother. The sexual relationship that resulted in the pregnancy represents a synthetic

substitute for love and a desperate attempt to "hold on" to the love object, stopping at nothing to gain the personal attention she craves (Clark, 1967, p. 1466).

Accepting the rationale that illegitimate pregnancies are the result of an attempt to escape from an emotionally sterile or unhappy life, nursing intervention, sepcifically post-abortion counseling, might be of some benefit in preventing future illegitimate pregnancies and in reducing negative psychological sequelae of the abortion.

HISTORY AND CURRENT STATUS OF ABORTION LAWS IN THE UNITED STATES

Abortion practices were acceptable and recorded as far back as 1800 B. C. during the Egyptian era. The United States adopted anti-abortion laws in 1830. These same laws were still in force in all 50 states at the time of the first major reform bill in 1966 (Gendel, 1971, p. 520). Two specific events occurring during the 1950's undoubtedly contributed greatly to breaking the taboos against open discussion of abortion and preparing the way for a massive revolution of stagnant abortion laws. These events were: the news of the large scale use of abortion as a method of birth control in Japan; and the Arden House Conference on abortion held in 1954, in New York (Hardin, 1969, pp. 278, 279).

Certain basic facts brought out at this conference became the focal points for many of the abortion reform bills throughout the states. Calderone, (1958) a noted authority on abortions, brought out that in her opinion abortion is a method of birth control, and for most women it is the backstop method of birth control to be used when other methods

have failed. Another important fact from this conference was that in work done by anthropologists, it has been found that 99% of all societies studied used abortion as a method of birth control (Devereux, 1955). Another author agrees saying: "abortion is the most widely used single method of birth control in the world today" (Freedman, 1965, p. 157).

In the United States, the first model abortion reform bill was passed in 1966. Since then, legislative abortion reforms have occurred in rapid succession throughout the states.

Abortion Law in California

The California Therapeutic Abortion Act was passed November 8, 1967. The law permits a therapeutic abortion to be performed by a licensed physician in an accredited hospital up to the twentieth week of pregnancy. All therapeutic abortions must be approved in advance by a committee of the medical staff of the hospital. The committee must find one or more of the following conditions:

> 1. There is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother.
> 2. That the pregnancy resulted from rape or incest (California Interagency Council on Family Planning Newsletter, 1970, p. 3).

In the first year of its operation, the California Therapeutic Abortion Act provided some 5,000 safe therapeutic abortions to women who otherwise may have risked illegal and dangerous solutions to an unwanted pregnancy. Of these 5,000 abortions, 86% were for mental health, 6% for physical health, and 6% for rape or incest (Overstreet, 1968). In 1969, a total of 15,339 therapeutic abortions were performed. Therapeutic abortions performed in 1970, numbered 62,339. This shows a tremendous increase over the previous year, representing a rate of 172 abortions per 1,000 live births. Of the 1970 applications for therapeutic abor-

tions, 98.2% were made on the grounds of the mother's mental health, 1.1% for reasons of physical health, and 0.7% on the basis of rape or incest (California Health, 1971, p. 14).

Contrary to previous reports, Thompson, et al. (1970) documents the findings that the majority of legal abortions are being done on the single teenage group (p. 993). California shows that at least 60% of the abortions are done for unmarried women under the age of 25 years (State of California, Department of Public Health, 1970).

Because at least half of all abortions are performed on women under 25 years of age, and since there is a significant increase in the percentage of abortions performed for mental health reasons, special attention should be given to the psychological problems involved in abortions. The nurse counselor may be useful in helping the emotionally vulnerable adolescent gain some insight into the psychological problems which caused the first illegitimate pregnancy, and thereby begin the process toward a more mature and balanced attitude toward sexuality.

Since legalization of the abortion laws, health departments are required by law to provide counseling and referrals to those women who request abortions. Community health nurses are, by necessity, having to become more knowledgeable regarding abortion counseling and resources for women who want to terminate their pregnancy. Tyler and Schneider (1971) foresee that new abortion services must be provided for the public and they include:

1. Public education
2. Patient counseling and referral
3. Safe surgical care, including pre- and post-abortion evaluation and counseling

4. Contraceptive counseling to prevent further unwanted pregnancies and subsequent abortions (p. 491).

PSYCHOLOGICAL SEQUELAE OF ABORTION

The following research studies have been done to determine psychological reactions to therapeutic abortions done for mental health reasons; they lend credibility to the necessity for my study. In the following reports, one finds that conclusions range from the suggestion that a therapeutic abortion almost always produces severe psychological sequelae to the opposite idea of complete absence of any post-abortal complications.

European Studies

One of the first valid studies on psychological reactions to abortion was done by Ekblad (1955) in the late 1940's. A total of 479 Swedish women were studied for post-abortion psychiatric sequelae. Twenty-five percent of the women experienced mild (14%) or serious (11%) self-reproach and guilt following the abortion. Ekblad's conclusion was that legal abortions do cause guilt and other adverse psychological problems in some cases, but that these undesirable sequelae are not so serious as to cause irreparable psychological damage.

Siegfried (cited by Simon and Senturia, 1966, p. 380) and Malmfors (1958) reported studies done on European women who had legal abortions. Their reports confirm Ekblad's study in that they found significant levels of guilt feelings, depression, and anxiety neurosis following abortions. Arens (1958-1959) interviewed 100 women three years following the abortion and found that 25% stated they would not go through with another abortion even if it were another unwanted child

(p. 64).

In London, a study by Pare and Raven (1970) on 131 unmarried women revealed few serious post-abortal psychiatric disturbances. Mild feelings of guilt and loss were not unusual--often lasting 1-2 weeks, and in 13% of the women lasting longer than 3 months after the abortion.

American Studies

A significant follow-up study by Patt, Rappaport, and Barglow (1969) was conducted on 35 patients from 1964-1968 in Chicago. Twenty of the 35 women reported feeling "relieved and relaxed" following their therapeutic abortion. However, 15 (43%) experienced short-term suicidal or self-mutilative feelings, somatic symptoms, and depression which lasted for a period of from 2-6 months.

Niswander, et al. (1967) surveyed 116 patients following their therapeutic abortions and found that 95% of the women were sure that legal abortions were the best solution to their problem. Twenty-five percent did experience short-term unfavorable reactions to the abortion, and 5% long-term psychological sequelae.

Kretzschmar and Norris (1967), in studying 24 patient's post-abortion psychological adjustment and mental health, found that 12 (50%) experienced depression after the abortion. Three of the patients sought psychiatric help during the post-abortal period, but no permanent sequelae were noted.

In contrast, Marder (1970a) reviews the experience of the Los Angeles County University of Southern California Medical Center with 147 patients who obtained legal abortions under the new California abortion law. He found "no serious emotional problems of guilt or

remorse occurring in the post-abortal period" (p. 1236).

Kummer (1963) along with a certain number of psychiatrists, firmly believe that post-abortion psychiatric illness and guilt is rare and reports indicating the presence of such is but a "myth" (p. 983).

Other psychiatrists share Lidz's belief that "abortion is a serious assault on the integrity of the body and a tremendous threat to the integrity of the ego structure" (Lidz, 1954, p. 279). He also believes that guilt and subsequent depression are in some cases the result of the fetal loss through abortion. He does go along to say that serious psychiatric reactions are much more rare than severe emotional reactions to an unwanted pregnancy, childbirth, and motherhood.

Janis (1958) feels that any surgical operation on a woman's body may leave psychological scars. These "scars" may be guilt, regret, or remorse because of the abortion (Crowley and Laidlaw, 1967, p. 4).

The psychological support of the nurse counselor after the abortion may help the adolescent work through feelings of depression and guilt which may follow fetal loss; this counseling may also help to prevent permanent psychological sequelae.

ADOLESCENT ATTITUDES TOWARD ABORTION

The majority of abortions are being done for the unmarried adolescent group. Since abortion is becoming one of the acceptable solutions to an unwanted pregnancy, adolescent attitudes toward abortion are important.

A recent study on adolescent attitudes toward abortion was conducted in San Francisco by Gabrielson, _et al._ (1971). A large sample of adolescents was selected for comprehensive questioning and testing.

Results from this study indicate several important facts:

1. The older adolescents were much more accepting of abortions than the younger ones.

2. Girls currently practicing any religion were less accepting of abortion than those who had never professed a specific religious affiliation. Practicing Catholics did not differ significantly from others.

3. A majority of the group felt that an abortion would leave a girl with a great many guilt feelings.

4. One-third of the group equated abortion with killing.

5. Those adolescents who were more favorable towards abortion tended to be higher in socio-economic status, older, and without current religious affiliation (pp. 730-737).

The study also indicated that these girls were experiencing internal conlicts and ambivalent feelings with regards to their responses concerning abortion. This is not surprising since adolescence is a time of ambivalence, inconsistancy, and self-contradiction (Keniston, 1970, p. 1). Because of the adolescent's intense anxiety and emotional instability, Gabrielson (1971) believes that "supportive counseling would help pregnant teenagers in decision-making and in accepting the consequences of their decisions" (p. 737).

RATIONALE FOR POST-ABORTION COUNSELING

Psychiatrists, as a whole, are in agreement that whereas therapeutic abortion does not in itself result in permanent, serious psychological sequelae, it is still considered a procedure with emotional and psychological consequences. Affective disturbances which may occur

during the immediate post-abortal period represents a need for appropriate counseling and follow-up. One major problem concerning therapeutic abortions is the lack, or complete absence of follow-up. Connor (1970) feels that "termination of pregnancy must be considered just the beginning of treatment," and that any patient who has a therapeutic abortion for psychiatric reasons should have an outlined plan for post-abortion follow-up (p. 137).

The pregnant adolescent is experiencing the developmental crisis of adolescence (Mamlet, 1968, p. 139), as well as a sitational crisis of an unwanted pregnancy (Matheney, 1970, p. 321; Senay, 1970, p. 408). Many girls attempt to resolve this crisis by a legal therapeutic abortion. The abortion itself, however is not adequate final therapy and seldom a complete solution to the girl's problem (Stallworty, 1970, p. 396; Pike, 1969, pp. 318-319). Galdston's (1958) opinion is that while abortion may bring some immediate relief to the problem of the unwanted pregnancy, there are a number of individuals who experience adverse rather than remedial reactions to the abortion (pp. 117-121).

Abortion has its own negative psychological affects which, although often silent and unobserved, may erupt to only amplify the original crisis (Kimball, 1970, p. 396). Some of these more frequent affects are reported to be:

1. Depression (Klerman, 1970, p. 32; Schoenberg, _et al_., 1970 p. 193).
2. Frustration, Anxiety, and Hostility (Galdstone, 1958, p. 121).
3. Grief and Loss (West, 1970, p. 1923; Senay, 1970, p. 410).
4. Remorse and Guilt (West, 1970, p. 1923; Harrison, 1970, pp. 366-367).

Although the adolescent girl requests and may really wish to have the pregnancy interrupted, serious consideration must be given to the emotional affects and possible "serious emergency reaction" to the abortion (Freedman, et al., 1967, p. 1085).

A planned individual counseling program during the immediate post-abortal period is needed to help the adolescent:

1. Clarify her ambivalence about the abortion;
2. Re-identify her reasons and need for the abortion;
3. Help her recognize her feelings of loss and guilt as the result of the abortion;
4. Help her see the positive aspects of her decision to have the abortion;
5. Aid her in planning some form of contraceptive practice to prevent recurring unwanted pregnancies (McEwan, 1970, p. 430; Kimball, 1970, p. 296; Pike, 1969, p. 320).

In counseling the adolescent who has had an abortion, the nurse must bear in mind that, because of the adolescent's fears and impulsive behavior, she wants to feel protected (Josselyn, 1968, p. 480) and to have the assurance she will be listened to and believed (Frank, 1967, p. 1443). By escaping or retreating from a difficulty or responsibility a person develops anxiety or guilt (Cattell, 1964, p. 399). The nurse needs to help these girls "understand and accept responsibility for their sexual behavior, and to help them appreciate the tragedy (and consequences) of creating an unwanted life" (Naugle, 1970, p. 41).

The nurse therapist must be willing to take an active and often directive role in the intervention. She must be able to use diverse and individualized techniques in her intervention and be flexible in

her approach.

The affects of anxiety, depression, hostility, and guilt are so intermeshed that it is impossible to counsel regarding each one separately. Gunn (1962) states that anxiety and depression are seldom seen alone (p. 1). Another viewpoint defines guilt as a form of anxiety and depression (Schottstaedt, 1960, p. 129). It is also believed that guilt feelings are often composite feelings, including at different times, anxiety, depression, longing, and shame (Ostow, 1959, p. 73).

Marder feels that "concern and proper care" for these adolescents may help to minimize the development of guilt, remorse, and depression in the post-abortal period (Marder, et al., 1970b, p. 661).

CHAPTER III

ANALYSIS AND INTERPRETATION OF DATA

The purpose of this experimental study was to evaluate the effectiveness of a post-abortion counseling program for unmarried adolescents in reducing negative affects which the adolescent may exhibit or feel immediately following the abortion. From a total sample of 28 clients who were selected for this study from June-November, 1971, data were collected on 20 unmarried adolescents who completed the post-abortion counseling program. The data presented here were obtained from a compilation of test scores for anxiety, depression, hostility, and guilt which were obtained at three different times, and a questionnaire completed by each of the clients at the end of the study.

DESCRIPTION OF THE STUDY SAMPLE

The Experimental Group

The ten clients selected for the experimental group were all unmarried caucasian adolescents ranging from 16-20 years of age; with the mean age being 17.7 years. The educational level ranged from completion of the ninth grade to completion of two years of college.

One client received financial assistance from the California Department of Welfare. The other nine clients obtained private funds for the abortion. Three clients informed one or both parents about the pregnancy and plans for the abortion. The other seven clients preferred

not to tell their parents anything about the pregnancy.

None of the experimental group reported using any method of birth control at the time of conception. One client had used birth control pills some months prior to the pregnancy but she had become sick and discontinued taking them. The other nine clients reported that they had never used any type of contraception. Three clients had no knowledge of the meaning of birth control or ways of preventing pregnancy. Six clients had heard of "the pill" but were either unable to obtain the pills, or they felt guilty taking them. Some expressed the feeling that if they took birth control pills, then sexual intercourse would be premeditated and planned. To them this was "wrong."

The researcher made the post-abortion visits to the homes of eight clients. One client preferred to see me at the health department for the follow-up visits, and the second client requested that I meet her at a small restaurant for follow-up visits.

The Control Group

From the ten unmarried adolescents selected for the control group, the Ethnic distribution consisted of six Caucasians, three Blacks, and one Mexican American. The ages of the control group ranged from 16-20 years with a mean age of 17.9 years. The educational level of the control group ranged from completion of the tenth grade to completing two years of college.

Three clients received Welfare assistance for financial payment of the abortion. The other 7 clients paid privately for the abortion. Six of the ten clients informed one or both parents of the pregnancy and involved them in the abortion plans.

Two clients reported using Delfin foam as a method of birth control at the time of conception. One client reported taking the "pill" some time prior to her pregnancy, but discontinued it "because I didn't think I'd need it." The other 7 clients reported never having used a method of birth control. The reasons for not using a birth control method was essentially the same as expressed by the experimental group. (See Table I for complete demographic data of the sample groups)

The meeting places for follow-up visits for the control group were somewhat varied from that of the experimental group. Only five clients felt comfortable about having me come to their home following the abortion. Three clients came to the health department for follow-up, and the two other clients chose to meet me at a laundromat and a local park for follow-up.

TREATMENT, PRESENTATION, AND INTERPRETATION OF THE DATA

Raw scores from the Anxiety, Depression, Hostility, and Guilt scales were obtained for each client using the BSTAT Computer Program. The individual score differences between tests were statistically analyzed for the mean, a standard deviation, and a t test. Analysis of the questionnaire dealing with abortion attitudes was done by comparing percentage values between the experimental and control groups.

The mean, mean difference, and the t-value of the anxiety, depression, hostility, and guilt test scores were separately computed for the experimental and control groups. Two sets of information was desired: 1) the score difference between the pre-test and the post-test I and II; and 2) the score difference between the post-test I and

TABLE I

COMPARISON OF DEMOGRAPHIC DATA FOR THE EXPERIMENTAL AND CONTROL GROUPS

Data	Experimental No.	Control No.
Ethnic Group:		
Caucasian	10	6
Black	0	3
Mexican-American	0	1
	10	10
Age:		
16 years	1	2
17 years	4	1
18 years	3	4
19 years	1	2
20 years	1	1
	10	10
Education:		
Completion of: 9th grade	1	0
10th grade	1	1
11th grade	2	2
12th grade	5	3
13th grade	0	3
14th grade	1	1
	10	10
Financial Support for Abortion:		
Self	7	4
Parents	2	3
Welfare	1	3
	10	10
Place of Post-Abortion Visits:		
Client's home	8	5
Health Department	1	3
Other	1	2
	10	10
Use of Contraception:		
No history of using birth control	9	7
Prior history of using birth control	1	1
Using birth control at time of conception	0	2
	10	10

post-test II.

Analysis and Comparison of Pre-test and Post-test I

The test given each client prior to her abortion was for the purpose of evaluating the client's psychological reaction to the unwanted pregnancy in terms of anxiety, depression, hostility, and guilt. Since clients in both the experimental and control groups were treated alike during the pre-abortion counseling session, it was hoped that data from these test would assure similarity of both research groups in terms of reaction to the pregnancy and the immediate response to the abortion.

Mean score values of anxiety, depression, hostility, and guilt indicate no significant difference in negative affective response to the pregnancy between the experimental and control groups. (Table II and Bar-Graft 1) With the anxiety, depression, and hostility tests, an increase in the score indicates an increase in the degree of anxiety, depression, or hostility present. Conversely, with the guilt scale, a low score indicates an increase in guilt while a high score indicates a decrease in guilt.

Mean differences between the scores on the pre-test and those on the post-test I indicate a trend which is of clinical interest. The total mean scores from the pre-test of all 20 clients was compared with the corresponding mean values of the post-test I scores. (Table III) This comparison was for the purpose of determining if the abortion itself would significantly reduce the negative affects expressed towards the crisis of the unwanted pregnancy. The mean values as shown on Table III indicate that the negative affects experienced as the result of the

TABLE II

*SIMILARITY OF RESPONSE TO THE UNWANTED PREGNANCY BY COMPARISON OF MEAN TEST SCORES BETWEEN THE EXPERIMENTAL AND CONTROL GROUPS

Affect	Score Range	Mean of Normal 18 year old Females	Experimental		Control	
			No.	Mean	No.	Mean
Anxiety	0-21	6.3	10	12.6	10	12.7
Depression	0-40	13.6	10	19.0	10	21.7
Hostility	0-28	7.2	10	10.5	10	12.9
Guilt	14-70	None	10	45.8**	10	47.3**

* See Bar-Graft 1
** See Guilt Index (Appendix G)

BAR-GRAFT 1

SIMILARITY OF BOTH GROUPS' REACTIONS TO
THE UNWANTED PREGNANCY

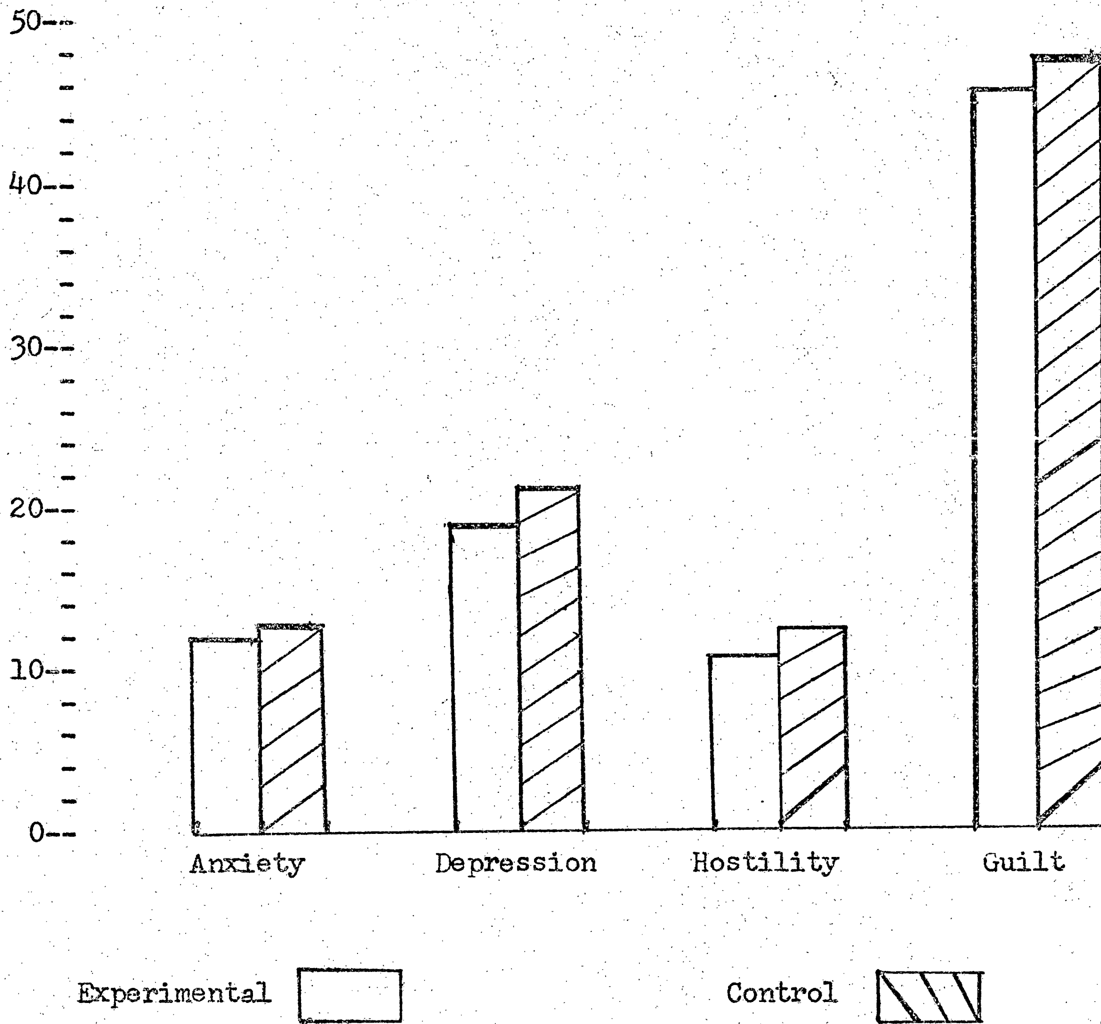


TABLE III

COMPARISON OF MEAN VALUES FOR ANXIETY, DEPRESSION, HOSTILITY AND GUILT BETWEEN POST-TEST I AND POST-TEST II

Affect	Sample Size	Pre-Test Mean	Post-Test Mean	Mean Difference	Percent of Decrease
Anxiety	20	12.65	6.95	6.70	45%
Depression	20	20.35	12.20	8.15	40%
Hostility	20	11.70	9.40	2.30	20%
Guilt	20	46.55*	51.70*	5.15	10%

* A Decrease in Guilt is indicated by a higher test score

unwanted pregnancy were significantly decreased. Within 0-3 days after the abortion, anxiety, as exhibited prior to the abortion, was reduced by 45%, depression 40%, hostility 20%, and guilt 10%. The mean difference in the values in Table III are significant at the .05 level.

These statistical results show that a therapeutic abortion does significantly reduce negative affects, exhibited prior to the abortion, which may be the result of an unwanted pregnancy.

Analysis and Comparison of Data From Post-test I and Post-test II

The following null hypothesis was proposed: There is no difference in the reduction of negative affects exhibited among unmarried adolescents who received post-abortion counseling and those who received no counseling.

The mean difference between scores from post-test I and post-test II were statistically computed and tabulated. (Table IV) A t test was applied to the data to determine whether there was a significant reduction in negative affects between the experimental and control groups. The following formula was used to obtain the t statistic:

$$T = \frac{\bar{X}_1 - \bar{X}_2}{\sqrt{1/N_1 + 1/N_2}} \qquad \text{where } Sp = \sqrt{\frac{(N_1 - 1)_{S_1}{}^2 + (N_2 - 1)\, S_2{}^2}{n_1 + n_2 - 2}}$$

The t test is used to test the chance probability of a difference between the means of 2 small samples (Phillips and Thompson, 1967, p. 354). With 18 degrees of freedom at the .05 level of significance the two groups were not different with respect to changes in levels of anxiety, hostility

TABLE IV

COMPARISON OF THE EXPERIMENTAL AND CONTROL MEAN DIFFERENCES AND T-VALUES BETWEEN POST-TEST I AND POST-TEST II

Affects	EXPERIMENTAL Mean difference between tests	CONTROL Mean difference between tests	T-Values
Anxiety	0.00	0.70	.5610
Depression	-.80	2.50	2.1395*
Hostility	1.40	1.50	.0995
Guilt	-3.90	-2.10	.6568

* Significant at the .05 level

TABLE V

THE EXPERIMENTAL AND CONTROL MEAN VALUES OF POST-TEST I AND POST-TEST II

	POST-TEST I		POST-TEST II	
Affects	Experimental Mean	Control Mean	Experimental Mean	Control Mean
Anxiety	7.3	6.6	7.1	5.9
Depression	12.7	11.7	13.5	9.2
Hostility	9.4	9.4	8.0	7.9
Guilt	51.7	51.7	55.6	53.8

and guilt. However, the t value of 2.1395 for depression is significant at the .05 level of significance. The mean depression score of post-test II for the control group was 9.2 while the mean for the experimental group was 13.5.

Discussion

From the statistical findings presented, the null hypothesis was accepted. The study hypothesis was rejected in that the post-abortion counseling program did not significantly reduce anxiety, hostility, or guilt affect levels of the experimental group as compared to the control group. The time period allotted for testing negative affective responses was limited to two weeks post-abortion. Because of the low levels of anxiety, hostility, and guilt immediately following the abortion and prior to any nursing intervention (Table II) it appears that at least for this sample group, the abortion experience did not seem to be a crisis within the context of test scores used for this study.

The comparison of the experimental mean values of anxiety, hostility, and guilt between post-test I and post-test II indicate a very slight decrease in these affective levels after the counseling program. (Table V) However, the difference is of no statistical value.

Depression appears to be significantly increased in the experimental group after nursing intervention was given. (Table IV and V) No clinically established explanation can be given for this increase in depression. However, it is felt by the researcher that presentation of possible explanations would be of value. On the first post-abortion visit nearly all of the experimental clients expressed the feeling that "This whole thing (meaning the abortion experience) seems so unreal to

me--I can't believe it's really happened." Coleman (1964) identifies this type of reaction to an unpleasant situation as denial of reality--or escapism. This is one of the most primitive of all ego defense mechanism or non-awareness" (p. 75). This unpleasant reality is ignored, or transformed so that it is no longer unpleasant or painful.

The researcher speculates that denial was possibly used by the adolescents in this study to protect them from the full impact of the trauma of the abortion experience. This denial then prevented them from giving accurate affective responses on the tests administered immediately following the abortion. Crisis-oriented nursing intervention may have been effective in helping the adolescent face the reality of the abortion and to talk about her feelings and reactions to the abortion. In being able to face her true feelings, she was then able to more accurately describe her affective responses to the abortion on the tests given after the counseling sessions. This might then account for the increase in the depression scores.

Another aspect which should be considered is the adolescent's response to the fetal loss. Since the depression represents a reaction to loss (Thaler, 1966, p. 12), it might be that the adolescent was still in the process of working through her grief when the counseling was concluded. Elisabeth Ross (1969) who has worked extensively with grief and loss, feels that the grieving process consists of five stages:

1. Denial and Isolation
2. Anger
3. Bargaining
4. Depression
5. Acceptance

It may be that the adolescent was tested while she was still in the depression stage, thus accounting for the increase in the depression scores.

Parental knowledge of the adolescent's pregancy and plans for an abortion may influence the adolescent's reaction immediately after the abortion. In this study, six adolescents in the control group compared with only three in the experimental group informed the parents of the unwanted pregnancy and plans for an abortion. If there was a positive relationship with the parents, the adolescent who involved her parents in this crisis may have received emotional support which helped her work through her grief and depression. As noted above, there was a significantly higher number of adolescents in the control group as compared with the experimental who involved parents. This might be another possible explanation for the increased level of depression among the experimental group.

There may be a physiological cause of depression immediately following an abortion. During pregnancy, the estrogen and gonadotropine hormone level is elevated. However, after an abortion, there is a sudden drop in these hormone levels which some medical authorities feel may produce slight depression. For this sample, hormone levels were not obtained, therefore it was not possible to determine the hormone level of each client immediately following the abortion. None of the clients in this sample took any estrogen medicine during the two weeks post-abortion. Because the control group had significantly less depression after the counseling than the experimental group, it cannot be concluded for this study that depression was caused by a sudden drop in

hormone levels since both groups were subject to the same physiological response.

All the adolescents in the experimental group expressed the feeling that the counseling was beneficial to them. They reported greater insight into their feelings and reactions to the unwanted pregnancy and abortion. They also felt that the assurance and support communicated in the counseling was effective in helping them make a satisfactory adjustment to the abortion. They reported that the medical information received in the counseling sessions was instrumental in reducing fears regarding physiological changes following the abortion. Another aspect of the counseling which the adolescents appreciated was information regarding birth control and resources where contraceptive devices might be obtained. During the post-abortal period each client in the experimental group either initiated a request for, or responded in a very positive way to the subject of contraception. No client expressed any ambivalence or guilt feelings regarding the use of contraception after the abortion. As stated previously, the primary reason as given by this sample for not using contraceptives prior to the unwanted pregnancy was due to the severe guilt feelings associated with a pre-meditated sexual relationship which would occur as the result of the use of contraception. As far as the investigator knows, all clients in the experimental group did obtain and begin using contraceptive pills within one month following the abortion. Follow-up of contraceptive practices with the control group was not done.

Analysis of the Abortion Questionnaire

Sixteen of the twenty clients completed the questionnaire

designed to test general attitudes of adolescents towards the moral and legal abortion issues. (Appendix D) Responses to the individual questions are shown by percentages of each group in Table VI and Bar-Graft 2. A four-point scale was provided for responses to the second set of questions. However, for scoring and tabulating purposes, the responses were divided as agree/disagree.

It is of interest to note that 100% of both groups questioned were in agreement that "Barbara" made the right choice by having a therapeutic abortion; and on question 2A, that abortion is really safe if it is done in a good hospital. A higher percentage of clients in the experimental group, in comparison to the control group, expected abortion to be followed by guilt feelings and also equated abortion with killing. Because the questionnaire on abortion attitudes was completed at the end of the second post-abortion visit, the researcher did not explore with or question the client's response to each individual question. Perhaps the increase of depression among the experimental group could be attributed to the recognition of guilt which is a form of depression. Sixty-six percent of the experimental group as compared with 57% of the control group felt that they could not go through with another abortion. Both groups strongly agree that abortion is the best alternative to an unwanted pregnancy and that it should be legally available to anyone who wants it.

Responses of the adolescent to these questions suggest internal conflict. One hundred percent of the group approved Barbara's decision to have an abortion and 88% feel abortion is a better choice than bearing an unwanted child. Yet almost 63% of the group reject another abortion for themselves. Fifty percent of the group feel they would be

TABLE VI

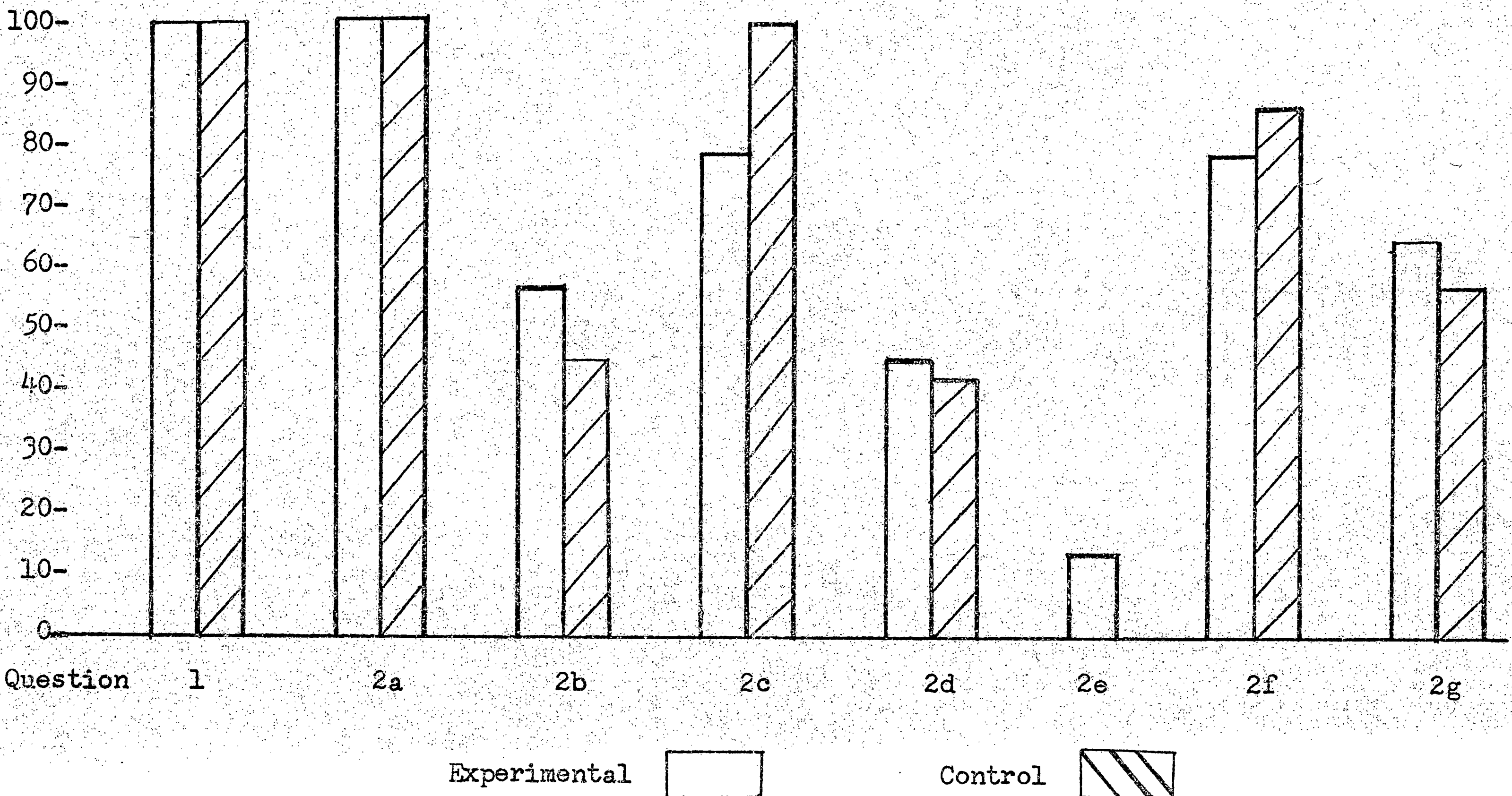
GROUPS RESPONSE TO QUESTIONS REGARDING ATTITUDES ON ABORTION

No.	Question	Experimental		Control	
		No.	Percent	No.	Percent
1	Barbara made the right decision to have the abortion.	9	100	7	100
2a	Abortion is really safe if done in a good hospital.	9	100	7	100
2b	Abortion will leave the girl with a great many guilt feelings.	9	55.5	7	42.8
2c	Abortion is a better choice than giving birth to a child you don't want and cannot care for properly.	9	77.8	7	100
2d	Abortion is a bad thing because it is like killing someone.	9	44.4	7	42.8
2e	If a girl fools around and gets pregnant, its her own fault and she should not be able to get an abortion.	9	11.1	7	0
2f	Abortion should be legally available to anyone who really wants it.	9	77.7	7	85.7
2g	Even if I had another unwanted pregnancy, I could not bring myself to have another abortion.	9	66.6	7	57.1

The percentage expressed indicates agreement to the question

BAR-GRAFT 2

SIMILARITY OF BOTH GROUPS ATTITUDES TOWARD ABORTION BY PERCENTAGE SCORES



left with guilt feelings, and 40% equate abortion with murder.

The suggested ambivalence here among adolescent girls regarding abortion may be the result of an ill-defined set of moral values toward sexual behavior and abortion.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

Within the past few years, therapeutic abortions have become legal in many states. Because of California's Therapeutic Abortion Act of 1967, legal abortions have increased from 5,000 in 1967 to 62,339 in 1970. At least 60% of these abortions are being requested by unmarried women under 25.

The community health nurse is becoming more involved in abortion counseling and referrals. Concern has been expressed regarding the lack of counseling and follow-up of unmarried adolescents who have therapeutic abortions.

Controversy continues to exist among the medical profession as to the presence or absence of post-abortion psychological sequelae. There appears to be enough significant data from literature to verify the possibility of adverse psychological reactions to a therapeutic abortion. The purpose of this study was to evaluate a post-abortion counseling program to determine if counseling might reduce negative affects exhibited during the immediate post-abortion period.

This experimental study utilized a sample composed of 20 unmarried adolescents randomly divided into an experimental and a control group. The girls were between the ages of 16-20 years. Each client in

the experimental group was visited by the researcher two separate times after the abortion and received crisis-oriented post-abortion counseling. The control group received no counseling.

The clients' negative affective response to the pregnancy and abortion experience was measured by Zuckerman's MAACL test and a Likert-type scale measuring guilt. Both groups were tested three separate times: (1) prior to the abortion (2) within 2-3 days following the abortion, and (3) 2-3 weeks after the abortion. The same two tests were administered each time. The clients' general attitudes toward abortion were also measured by the completion of a selected questionnaire.

Mean differences in affect levels of the experimental and control group between pre-test and post-test I, and post-test I and post-test II were compared. In both groups there was a significant decrease in anxiety, depression, hostility, and guilt immediately following the abortion. There was no significant statistical difference in the anxiety, hostility, and guilt affective levels following nursing intervention between the experimental and control group.

The experimental group did show a statistically higher level of depression, after nursing intervention, over the control group. A possible explanation may be the use of denial of the abortion experience among adolescents. Nursing intervention may have been successful in uncovering these feelings of denial, thus permitting them to face reality. In general, the experimental sample expressed positive responses to the counseling program.

CONCLUSIONS

This study resulted in the following conclusions:

1. The hypothesis for this study was rejected. Since the results showed no significant statistical data it cannot be concluded that a post-abortion counseling program significantly lowers negative affects during the immediate post-abortal period.

2. A significant increase in depression among the experimental group after the counseling indicates the possibility that the adolescent may have still been in the process of working through her grieving and was in need of further counseling.

3. The use of crisis intervention as outlined with the post-abortion counseling program did not prove to be the best method of nursing intervention. The adolescents in this study presented no crisis immediately following the abortion as indicated through verbalization or the tests which were given.

4. With both the experimental and control groups negative affects experienced as a result of the unwanted pregnancy were significantly reduced immediately after the abortion.

RECOMMENDATIONS

The following recommendations might be considered by those conducting studies on this problem:

1. If loss and grief do play a part in the adolescent's reaction to an abortion, then continued counseling and periodic testing should be done until the final stage of acceptance is reached.

2. Another study designed to evaluate an experimental and

control group, would be useful in evaluating the role of post-abortion counseling in the successful use of contraceptive measures by adolescent girls.

3. Based on the remarks made by many clients in this study, intensive crisis intervention immediately prior to the abortion would be of benefit and studies to evaluate the effectiveness of such counseling are recommended.

4. Follow-up testing of the control group 3-6 months following the abortion would be beneficial to determine if there is manifested any latent negative psychological sequelae to the abortion.

5. To identify the high-risk group, matched groups of adolescent unmarried and married women who have abortions, should be compared.

6. It would be beneficial to study the family interaction of each adolescent with emphasis on family strengths, weaknesses, and communications between the adolescent and one or both parents. The emotional closeness or distance which the adolescent feels towards her parents may influence her reaction to an abortion and her ability to adapt to this crisis.

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APPENDIX A

THE MULTIPLE AFFECT ADJECTIVE CHECK LIST

*The form of this test has been revised for the purpose of this thesis. The words are the same as found on the original test.

1 __active
2 __adventurous
3 __affectionate
4 __afraid
5 __agitated
6 __agreeable
7 __aggressive
8 __alive
9 __alone
10 __amiable
11 __amused
12 __angry
13 __annoyed
14 __awful
15 __bashful
16 __bitter
17 __blue
18 __bored
19 __calm
20 __cautious
21 __cheerful
22 __clean
23 __complaining
24 __contented
25 __contrary
26 __cool
27 __cooperative
28 __critical
29 __cross
30 __cruel
31 __daring
32 __desperate
33 __destroyed
34 __devoted
35 __disagreeable
36 __discontented
37 __discouraged
38 __disgusted
39 __displeased
40 __energetic
41 __enraged
42 __enthusiastic
43 __fearful
44 __fine
45 __fit
46 __forlorn
47 __frank
48 __free
49 __friendly
50 __frightened
51 __furious
52 __gay
53 __gentle
54 __glad
55 __gloomy
56 __good
57 __good-natured
58 __grim
59 __happy
60 __healthy
61 __hopeless
62 __hostile
63 __impatient
64 __incensed
65 __indignant
66 __inspired
67 __interested
68 __irritated
69 __jealous
70 __joyful
71 __kindly
72 __lonely

73 __lost
74 __loving
75 __low
76 __lucky
77 __mad
78 __mean
79 __meek
80 __merry
81 __mild
82 __miserable
83 __nervous
84 __obliging
85 __offended
86 __outraged
87 __panicky
88 __patient
89 __peaceful
90 __pleased
91 __pleasant
92 __polite
93 __powerful
94 __quiet
95 __reckless
96 __rejected
97 __rough
98 __sad
99 __safe
100 __satisfied
101 __secure
102 __shaky
103 __shy
104 __soothed
105 __steady
106 __stubborn
107 __stormy
108 __strong
109 __suffering
110 __sullen
111 __sunk
112 __sympathetic
113 __tame
114 __tender
115 __tense
116 __terrible
117 __terrified
118 __thoughtful
119 __timid
120 __tormented
121 __understanding
122 __unhappy
123 __unsociable
124 __upset
125 __vexed
126 __warm
127 __whole
128 __wild
129 __willful
130 __wilted
131 __worrying
132 __young

APPENDIX B

LIKERT-TYPE SCALE MEASURING GUILT

Look at each word carefully; then choose one response that describes how you feel right now and place it's number by the word.

Word			Response
1.	ACCEPTABLE	______	1. Not at all
2.	AMBITIOUS	______	2. Very little
3.	ASHAMED	______	3. Some
4.	BAD	______	4. Quite a bit
5.	BLAMELESS	______	5. Very much
6.	CONDEMNED	______	
7.	CONFIDENT	______	
8.	DISGRACEFUL	______	
9.	GENEROUS	______	
10.	GUILTY	______	
11.	HUMOROUS	______	
12.	INNOCENT	______	
13.	LAZY	______	
14.	REBELLIOUS	______	
15.	RESPECTABLE	______	
16.	RESTLESS	______	
17.	TALKATIVE	______	
18.	UNACCEPTABLE	______	
19.	USELESS	______	
20.	WORTHWHILE	______	

APPENDIX C

NURSING INTERVENTION GUIDE

POST-ABORTION COUNSELING PROGRAM

Nursing intervention for the adolescents in the experimental group was accomplished during the two post-abortion visits. Counseling was implemeted through 1) Assessment 2) Planning intervention 3) Intervention and 4) Resolution of the crisis and anticipatory planning. The following plan for each of the two visits is a guide only in that each individual presented unique problems and the intervention was adapted to meet these individual needs.

First Post-Abortion Visit

At this visit assessment was made of the adolescent's physical health. The temperature was taken on each adolescent to determine if an infectious process was present. This physical assessment was to provide assurance to the adolescent that she was recovering physically from the abortion in a satisfactory manner. Also at this visit, rapport was established with the adolescent. Each client was encouraged to tell the investigator the general sequence of events concerning the abortion experience; focusing primarily on activities rather than feelings. A primary goal for this visit was to provide the adolescent with information regarding normal physiological reactions to the abortion. It was hoped that this information would reduce fear and anxiety which might occur as the result of these normal body changes.

Second Post-Abortion Visit

At this second visit I encouraged the client to talk about her feelings and reaction to the abortion. Emotional responses to the unwanted pregnancy was also encouraged. Through verbalization of these

experiences, suppressed or actual feelings of anxiety, depression, hostility, guilt, loss, and grief could be expressed. This also provided emotional catharsis for the adolescent. Nursing intervention was directed towards helping the adolescent gain an intellectual understanding towards the crisis and to accept her feelings about the abortion which she may have been denying to herself. Past crises were explored in an attempt to identify the client's coping mechanisms which may have been used to resolve these. After resolution of the adolescent's negative responses to the abortion, anticipatory planning was explored emphasizing contraception as a plan to prevent similar crises of an unwanted pregnancy and abortion. At the end of the visit, the counselor reviewed with the adolescent her progress towards a healthy acceptance and understanding of the abortion. Where needed, assistance was given in helping the adolescent make realistic plans for the future.

APPENDIX D

QUESTIONNAIRE ON ABORTION ATTITUDES

Mark the one response to each statement that describes your feelings about abortion.

Barbara was really upset when she found out that she was pregnant.

She went to her doctor and was able to arrange an abortion.

Imagine you were a close friend of Barbara, and she told you about this.

How would you feel about what Barbara did? (check one)

a. _______ She did the wrong thing. She should have gone on and had the baby.

b. _______ She should have had the baby, and then if she couldn't take care of it she should have arranged for an adoption.

c. _______ She did the right thing if she really didn't want to have a baby.

1. agree strongly
2. somewhat disagree
3. agree somewhat
4. strongly disagree

a. Abortion is really safe if it is done in a good hospital.
1_______ 2_______ 3_______ 4_______

b. Abortion will leave the girl with a great many guilt feelings.
1_______ 2_______ 3_______ 4_______

c. Abortion is a better choice than giving birth to a child you don't want and cannot care for properly.
1_______ 2_______ 3_______ 4_______

d. Abortion is a bad thing because it is like killing someone.
1_______ 2_______ 3_______ 4_______

e. If a girl fools around and gets pregnant, it's her own fault and she should not be able to get an abortion.
1_______ 2_______ 3_______ 4_______

f. Abortion should be legally available to anyone who really wants it.
1_______ 2_______ 3_______ 4_______

g. Even if I had another unwanted pregnancy, I could not bring myself to have another abortion.
1_______ 2_______ 3_______ 4_______

APPENDIX E

PREGNANCY REFERRAL FORM

Pregnancy Referral

Date: ______________

1. Name ____

2. Address ____

3. Telephone: (home) ____________ (work) ______________
   o.k. to use o.k. to use

4. Age __________ Birth date ____________________

5. Religion ______________________ race ______________________

6. Years of schooling completed. (circle one) 8 9 10 11 12 13 14 15 16

7. Who supports you? yourself ______ parents ______ other __________

8. Are you on Welfare? Yes ________ No ________

9. Are you married __________ single _________ divorced __________

10. Date of last menstrual period _________________

11. Has pregnancy been verified? Yes ______ No ______ Where? ________

12. Were you using birth control when you became pregnant? Yes ___ No ___
    What kind? ________________________
    If no, Have you ever used any birth control? Yes _____ No _____
    If yes, what kind? ______________________________
    Why did you discontinue it? ____________________________

13. Have you been pregnant before? Yes ______ No ______
    If yes, how many children do you have? _______________
    Have you ever had an abortion? Yes ______ No ______

14. If you are pregnant, what are your plans? ____________________

COMPLETE IF PATIENT DECIDES TO HAVE AN ABORTION

Do you take medicines or drugs? Yes ______ No ______

Have you ever had psychiatric care for any reason? Yes _____ No _____

How do you feel about an abortion? _________________________________

Other comments

Referrals ____

Response to Family Planning Suggestion __________________________

APPENDIX F

CLIENT'S CONSENT FORM FOR THIS STUDY

CLIENT CONSENT FORM

Date: ____________

Name: ____________________

Recent legislation has made legal abortions available to many women who do not wish to continue with their pregnancy. Since public health nurses are giving assistance to girls desiring abortions, I am currently studying ways in which they can be most helpful. In order to obtain accurate information, I need and request your participation in this small study. It will require a few short visits with you and the completion of a simple question form.

Your name will never be used in this study, and all information will remain strictly confidential. Thank you for your assistance and cooperation.

Signed: ____________________

Date: ____________________

Researcher: ____________________

APPENDIX G

AN INDEX TO LEVELS OF GUILT

Guilt Index

APPENDIX H

LETTERS OF APPROVAL AND CONSENT

P.O. Box 863
Loma Linda, CA 92354

March 4, 1971

M. E. Cosand, M.D.
Director of Public Health
San Bernardino County Health Department
351 Mt View Avenue
San Bernardino, California

Dear Dr. Cosand:

Recent legislation has made legal abortions available to many unmarried women who do not wish to continue with their pregnancy. Currently, as well as in the future, public health nurses will be more involved in abortion counseling. From my observation and study, there seems to be little follow-up done on unmarried adolescent women having therapeutic abortions. I am interested in studying ways in which nurses can be most helpful to this particular group of women after the abortion. I wish to conduct a study to evaluate the effectiveness of a post-abortion counseling program in reducing the post-abortal anxiety and/or depression which may be present. Since some type of birth control method is advised as a means to prevent further unwanted pregnancies, I also plan to see if post-abortion counseling will increase better utilization of Family Planning Facilities.

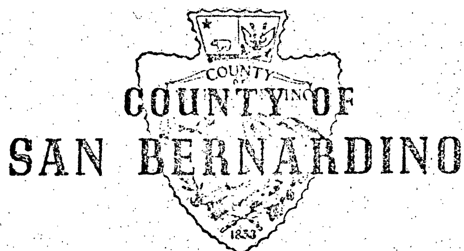
With your permission I will choose the sample group for my study from unmarried girls 16-21 years of age who come to the Health Department requesting abortions. The study will then continue as outlined in the research design which is enclosed. I will be working closely with my Research Committee at Loma Linda University: Ruth White R.N., M.S.; Clarice Woodward R.N., M.S.; and Erwin Crawford M.D. Also, I will be advising with Ruth Range at the Health Department.

Due to the availability of select patients at the Health Department which are needed for my study, I would greatly appreciate your permission to conduct this research at the San Bernardino County Health Department. Thank you for your consideration in this matter. I shall await your reply.

Sincerely,

Linda L. Levisen

M. E. COSAND, M.D.
Director of Public Health



COUNTY HEALTH DEPARTMENT
351 Mt. View Avenue

SAN BERNARDINO, CALIFORNIA 92401

April 7, 1971

Miss Linda L. Levisen
P.O. Box 863
Loma Linda, California

Dear Miss Levisen:

We would be pleased to cooperate in providing you permission to work with our Ruth Range in conducting a counselling program for post-abortion patients.

Sincerely,

M. E. COSAND, M.D.
Director of Public Health

MEC:bel

LOMA LINDA UNIVERSITY

Graduate School

POST-ABORTION COUNSELING AND ANXIETY LEVELS OF UNMARRIED ADOLESCENTS HAVING THERAPEUTIC ABORTIONS

by

Linda Levisen

An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

June, 1972

ABSTRACT

The purpose of this study was to evaluate the effectiveness of a post-abortion counseling program. It was hypothesized that unmarried adolescents who received counseling following a therapeutic abortion would exhibit significantly fewer negative affects than those who received no counseling. The affects measured were anxiety, depression, hostility, and guilt. Twenty clients were randomly selected for this study. Prior to the abortion, the twenty clients were tested for negative responses to the unwanted pregnancy. Ten clients received post-abortion counseling twice following the abortion and were tested at each visit for negative affective responses to the abortion. The other ten clients received no post-abortion counseling but were tested for negative affective responses twice following the abortion. Tools used to collect data for this study were the MAACL, an attitude scale measuring guilt, and an abortion attitude questionnaire. The statistical findings from the data indicate that there was significant negative affective responses to the unwanted pregnancy among both the experimental and the control groups. After the therapeutic abortion, these negative affects were significantly reduced at the .05 level, with a reduction of anxiety by 45%, depression by 40%, hostility by 20%, and guilt by 10%. In evaluating the effectiveness of the counseling in reducing negative affects, there was no significant statistical difference between the two groups except for the affect of depression. This was significantly increased, at the .05 level of significance, in the

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experimental group following the post-abortion counseling. Possible explanations for this may be the use of denial immediately following the abortion, and also the grief reaction to the fetal loss. Nursing intervention may have helped these adolescents look at their true feelings in a more realistic manner. Within the context of this study, it cannot be concluded that a post-abortion counseling program for two weeks post-abortion significantly reduces negative affective responses to an abortion. The results do suggest that further research in this area is needed.