A BEHAVIORAL SURVEY OF PRACTICES USED BY SELECTED COUNSELORS OF WOMEN WITH PROBLEM PREGNANCIES

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DEDICATION

With love to

Mike, for being such a loving and supportive husband who encouraged me and helped me in all kinds of ways, and

Scott, Nicholas, and Michael, for being such good children who gave up Mom's help and time in order that she might succeed.

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CHAPTER 1

INTRODUCTION

Since the alteration in abortion laws in 1970, nearly all aspects of care relating to abortion have been in a state of change as society has been adjusting to the modification. The change in the law made a procedure which was once designated as a criminal activity now legal. This change also shifted responsibility for the decision to obtain an abortion from the physician and the courts to the pregnant woman. This is not an easy decision and as Bracken (1977) stated, "there is growing evidence that many women find the decision to seek abortion highly stressful, possibly one of the most difficult decisions of their lives" (p. 266). For this reason there was agreement among most sources that a woman seeking an abortion should receive counseling (Baudry & Weiner, 1974; Bracken, 1977; Dunlop, 1978).

Many articles have been written about characteristics and attitudes that should be possessed by abortion counselors (Dunlop, 1978; Scott, 1972; Smith, 1982). Baudry and Weiner (1974) and Bracken (1977) reported on what should be included in counseling prior to an abortion and steps to be taken by the counselor to help the client to make a

decision she will always think was best for her. Bracken (1973) surveyed clients to determine if counseling was helpful to them, which technique was most helpful, and how the abortion experience was resolved by them. Bracken's (1978) research focused on decision making during pregnancy and why some women elect to carry these pregnancies to term. However, there has been little research undertaken to determine what counselors do to aid their clients with decision making during the assessment and planning intervention phases of their interviews. Therefore, it appeared appropriate to survey abortion counselors to determine what behaviors they exhibit in their practice to aid their clients in decision making.

Problem of Study

There are guidelines available to be used in counseling women who seek abortions (Baudry & Weiner, 1974; Bracken, 1977; Dunlop, 1978; Scott, 1972). However, there has been a lack of research to validate that these guidelines are being followed in practice. Therefore, the problem of this study was: Do abortion counselors adhere to their role functions in aiding women with problem pregnancies in their decision-making processes?

Justification of Problem

The number of abortions in the United States has been increasing each year since the United States Supreme Court decision Roe v. Wade, 410 U.S. 113 in 1973. In 1978 alone there were 1,409,000 voluntary abortions performed in the United States (Statistical Abstracts, 1981, p. 66). Each of these pregnant women needed counseling prior to taking the step for the abortion. The large number of abortions alone demonstrated the need for finding out how counselors help these women to make the decision to terminate the pregnancy.

In a study which explored the view of the client towards her own abortion, Freeman (1978) stated that "abortion was for most an emotionally upsetting experience" (p. 155). Freeman demonstrated that 24% of the group she followed reported that losing a child was the most difficult feeling, although clinics carefully avoided using the terms "baby" or "child." Another 14% of these women found decision-making to be the most difficult. Additionally, 7% had difficulty with self-acceptance. Freeman found 4 of 10 women were still troubled or perceived their abortions as too disturbing to think about four months after the induced abortion had taken place. She suggested that these same women demonstrated personality attributes that indicated

avoidance of feelings or negative self-images, while those who had resolved their feelings showed "positive self-image, greater sense of mastery and achievement, as well as willingness to express and cope with feelings" (Freeman, 1978, p. 153). Bracken (1977) stated that the ability to make a "high quality" decision is an important skill needed throughout one's whole life and that

> the decision to abort provides the counselor with a very useful opportunity for educating her clients in some of the rudiments of high quality decision-making while reviewing the clients' own decision to seek abortion. (p. 269)

Thus, the abortion counselor can assist the woman to gain decision making skills.

In addition to the unresolved issues discussed above, another syndrome occasionally occurs. Smith (1982) described the anniversary reaction as "a depression occurring around the anniversary date of the abortion or the date the pregnancy would have terminated naturally" (p.178). Usually these women display both emotional symptoms and vague somatic complaints. This is believed to be an incomplete or pathological grieving response and usually requires some type of psychological help for the woman to resolve her problem.

Another problem is that most counselors who deal with women who have problem pregnancies are not formally trained in an academic setting for this job. Most medical personnel

have no training for abortion counseling and may even have spent the last decade resolving their own conflicts over the subject of abortions (Smith, 1982). A study in 1974 of abortion counselors in mostly clinic settings found the counselors to be of varying backgrounds and with no formal training for their positions (Dauber, 1974). In her study it was found that one-fifth of the counselors had previously had abortions themselves. This may be helpful in establishing rapport between client and counselor but may also only serve as a cathartic experience for the counselor with unresolved feeling regarding her own experience (Smith, 1982). There is training for counseling of this type available through the National Abortion Federation or through Planned Parenthood-World Population, but little is known about the numbers of counselors who have had this training. There appears to be a lack of published research on these counselors since Dauber's (1974) survey of abortion counselors.

Adding to this apparent lack of training for abortion counseling is the diversity of women with problem pregnancies: teenagers, single women, married women, those presenting in mid-trimester, and the elderly multipara. Each of the above--teenager, single, married, mid-trimester, and elderly--bring to the counselor special needs associated with the named factor. It appeared that it was time

to find out how counselors are meeting the needs of this diverse group.

The adherence to guidelines on abortion counseling is also important for nursing. Since the 1970s nurses have assumed roles in all aspects of care of women who have abortions. Nurses care for women during the abortion process itself (Harper, Marcom, & Wall, 1972; Olson, 1980; Smith, 1982). These nurses need to know that the abortion counselor has taken the appropriate steps to aid the women in decision-making and to prepare them for the abortion itself. Emergency room nurses or psychiatric nurses may come into contact with women who experience psychological problems following an abortion in which the woman was not sure of her decision (Barglow, 1976; Smith, 1982). In addition, nurses have assumed the role of abortion counselor (Admire & Byers, 1981; Dauber, 1974; Easterbrook & Rust, 1977; Smith, 1982). Dauber (1974) stated that one third of 100 abortion counselors studied were nurses with varied educational backgrounds. These included RN (type of educational program not stated), nurse-practitioner, and Master's of Science in Nursing. Dauber (1974) and Smith (1982) both stated that most nursing education programs do not prepare nurses for the abortion counseling role. This study may help nurses to identify counseling behaviors which they need to initiate, reinforce, or augment.

Theoretical Framework

The concepts of crisis intervention served as the framework guiding the focus of this research. According to Caplan (1964), most people normally function in "consistent patterns with minimal self-awareness and sense of strain" (p. 38). People normally are called upon to do problem solving and do so by using habitual mechanisms and reactions. Caplan stated:

> Characteristically, the problem calls forth a variety of habitual problem-solving mechanisms, one of which solves the problem similarly and in a similar length of time to the way in which it has happened on previous occasions. (p. 38)

Caplan reiterated, however, that during a short period of time before the solution,

> the organism is in a state of tension but this is not excessive because the period is not longer than in previous experience, and the individual . . . has . . . developed the expectation of a successful outcome. (p. 38)

During a crisis, according to Caplan (1964), the problem grows out of proportion because "the problem stimulus is larger and the usual re-equilibrating forces are unsuccessful within the usual time range" (p. 39). The crisis process described above is similar to what happens to a normal woman who usually functions in society independently and well but who suddenly finds herself with a problem pregnancy. When she finds herself pregnant she

will first experience psychological shock (Scott, 1972) and may try to deny that she is pregnant. As symptoms of pregnancy increase, denial becomes harder to maintain and disequilibrium occurs. According to Aguilera and Messick (1982, p. 59) then "tension rises and discomfort is felt, with associated feelings of anxiety, fear, guilt, shame, and helplessness" (p. 59). As anxiety rises, a narrowing of perceptual awareness occurs and it may increase to such a degree of crippling that the individual can only see the problem and be unable to focus on the alternatives which are available as solutions to the problem. At this time, the person is ready for a major change and can usually be helped by another person.

Caplan (1964) stated that in every crisis is the opportunity for either psychological growth or psychological deterioration (p. 53). The major objective of crisis counseling and/or abortion counseling should be psychological growth on the part of the woman. The counseling should help her to mobilize her inner resources and to refine her problem solving techniques. If her usual decision-making skills need improvement, the counselor may educate her in principles of "high quality" decision making (Bracken, 1977; Janis, 1982).

According to Morley, Messick, and Aguilera (1967) there are four phases of crisis intervention:

(1) assessment, (2) planning intervention, (3) the intervention itself, and (4) resolution of the crisis and anticipatory planning. The present study primarily was focused on what abortion counselors do in phases one and two which helps the woman to decide for herself the intervention best for her, and what the counselors do in phase four when a follow-up is done to assure that the crisis has been truly resolved.

In the assessment phase, phase one, the counselor attempts to ascertain several things. These include: what this pregnancy means to this woman, what people influence her, her knowledge base, and her usual coping skills (Aguilera & Messick, 1982).

In planning intervention, phase two, the counselor and the woman review all of the options open to her and discuss how each could realistically be accomplished in her life. In this phase the counselor evaluates the coping pattern that the client uses for decision making. According to Janis and Mann (1982) there are five coping patterns: (1) "Unconflicted adherence"--in which the decision maker elects to continue whatever she is doing, ignoring information regarding the risk of losses; (2) "unconflicted change to a new course of action"--in which the client uncritically takes the most obvious course of action or whatever was

strongly recommended; (3) "defensive avoidance"--in which the client seeks to escape the conflict by shifting responsibility to someone else or by wishful rationalizations; (4) "hyper-vigilance"--in which the client frantically searches for an answer and uses a hastily contrived solution while ignoring other possibilities; and (5) "vigilance"--in which the client looks at all possibilities and appraises alternatives carefully before choosing (p. 51). Of the above, vigilance is the only way to arrive at a "high quality" decision. The abortion counselor can help the client to avoid the other types of decisions by pointing out unrealistic plans or rationalizations and ascertaining whether the client is using the advice of others for her decision.

To help the client realistically explore all her options, Janis and Mann (1982) advocated the use of a balance sheet. Using the earlier work of Janis, Bracken (1977) gave an example of a balance sheet (p. 270) showing positive and negative effects for both the client and her significant others. Educating the client regarding skills in decision making should result in not only a well thought-out decision involving the problem pregnancy but also in skills which will help the woman in decision making throughout her adult life.

Assumptions

For the purpose of this study the following assumptions were considered:

1. All women with problem pregnancies who are contemplating an abortion need counseling prior to the final decision.
2. A problem pregnancy which results in the woman contemplating an abortion is a crisis situation.

Research Questions

The following questions were proposed for this study:

1. Do abortion counselors adhere to recommended steps to aid women with problem pregnancies in decision making?
2. In which of the first two phases of counseling do abortion counselors score higher: assessment phase or planning intervention phase?
3. How often do counselors perform follow-up counseling after the abortion?

Definition of Terms

The following terms were defined for the purpose of this study:

1. Abortion--voluntary induced termination of a pregnancy during the first or second trimester.
2. Abortion counselor--any person, with no legal prerequisites for standardized formal education, who counsels women with problem pregnancies in an abortion clinic.

3. Abortion counseling--a discussion between a counselor and a woman with a problem pregnancy in which a decision is reached by the woman regarding the resolution of the pregnancy.
4. Assessment phase--the first phase of counseling in which the counselor is trying to establish baseline data on the client. Assessment behaviors were measured in Part I of the Zotti Abortion Counselor Behavior Tool.
5. Follow-up phase--the phase following the abortion in which the counselor follows up to determine coping mechanisms and current use of family planning methods.
6. Planning intervention phase--the second phase of counseling in which the counselor and woman review all available options. Planning intervention behaviors were measured in Part II of the Zotti Abortion Counselor Behavior Tool.
7. Problem pregnancy--any pregnancy in which the pregnant woman voluntarily considers an abortion.

Limitations

The sample selection was limited to abortion clinics in Texas which are either certified by the National Abortion Federation or which advertise in the yellow pages

of the telephone book. Therefore the results cannot be generalized beyond this target population.

Summary

The number of abortions in the United States has been greatly increasing each year. Since there are no formal academic programs nor legal requirements for abortion counseling, this study was done to survey abortion counselors regarding their role functions. The underlying theory for abortion counseling was crisis intervention. Assumptions were listed, research questions were proposed, and terms were defined for use in this study. Due to sampling techniques the results cannot be generalized beyond this sample.

A review of pertinent literature dealing with abortion, crisis intervention and decision making is presented in Chapter 2. Procedures used in collecting and treating data in this study are delineated in Chapter 3. Chapter 4 presents an analysis of collected data. The summary of the study is contained in Chapter 5. This chapter also presents a discussion of the findings, conclusions, implications, and recommendations.

CHAPTER 2

REVIEW OF LITERATURE

There has been a great deal written on the subject of abortion during the last decade. Guidelines have also been made available to be used in counseling women who seek abortions, but there has been little research validating the use of these guidelines. Therefore, this study was undertaken to assess abortion counselor performance. To build a foundation for this study, the literature was reviewed in five major areas: scope of abortion changes in the United States, psychological implications related to abortion, problem pregnancy counseling, abortion implications for nurses, and crisis intervention and decision making.

Scope of Abortion Changes in the United States

On January 22, 1973, it was announced that the Supreme Court's majority opinion favored a Texas woman of low socioeconomic status whose pseudonym was "Jane Roe." Carelli (1983) stated that this woman had not wanted the pregnancy that she was carrying but was unable to obtain an abortion since abortions for other than life-threatening circumstances were illegal and was unable to travel to an area where they were legal because she was indigent. After

delivering and giving up the child she challenged the state law prohibiting abortion and finally won her case in the United States Supreme Court. The Supreme Court ruled that a woman's right to privacy included the right to end an unwanted pregnancy. This ruling coincided with what one women's group (Boston Women's Health Book Collective, 1973) had been saying: "Abortion is our right--our right as women to control our bodies" (p. 138). Carelli stated that since that Supreme Court decision, 10 million legal abortions have been performed on American women.

The Supreme Court's 1973 decision, however, was not the end of the issue but the beginning of a heated controversy in the United States between those who feel a woman has the right to an abortion if she desires it and those who feel abortion is morally wrong. Many churches, such as the Lutheran Church-Missouri Synod, have maintained the stand that "non-therapeutic abortion is wrong" (Commission of Theology, 1970, p. 2). Carelli (1983) stated that those who opposed abortion have attempted to change the decision by amending the Constitution or acknowledging the fetus as a "person" but those attempts have failed. Other rules, instituted by states and local communities, tried to make abortions more difficult to obtain but were struck down by the United States Supreme Court in July, 1983 ("Supreme

Court Cites," 1983). Accordingly, these rules included required hospitalization for second-trimester abortions, a mandatory 24-hour waiting period, and recitation of lists of complications and other information. Thus it is obvious that, to quote Carelli (1983, p. 28a), the "controversy . . . still rages."

Other social changes during this decade of legal abortions include the location of clinics, abortion service providers, and demographic variables of the women seeking abortions. These are reflected in the following studies.

In 1980 Granberg and Granberg summarized the results of the nine General Social Surveys conducted by the National Opinion Research Center. The data were then combined to describe trends in national opinion. It was not reported what number of people were involved in these studies nor the survey methods used. Data were described using percentages, graphs, and regression coefficients at a significance level varying from .01 to .05. Attitudes regarding abortion were described according to race, religiosity, political ideology, rural or city domicile, and others. People who were less likely to approve of abortion included blacks, people of any faith who defined themselves as very religious, and rural populations. Correlation between political ideology and approval of abortion was very weak.

Henshaw, Forrest, Sullivan, and Tietze (1981) summarized the Sixth Annual Survey conducted by the Alan Guttmacher Institute. Researchers at the Institute surveyed 2,567 health institutions and private physicians providing abortion services in the United States. There was no information given regarding the survey instrument. All data were expressed in percentages. The authors found that availability of abortion has increased in all states but that only 5% of all abortions were performed in nonmetropolitan areas. This finding coincides with Granberg and Granberg's (1980) finding regarding attitudes toward abortion in rural areas. According to Henshaw et al., the trend has been from hospital to nonhospital facilities for abortion. The numbers also reflected a sharp increase in the number of nonhospital facilities.

According to Henshaw et al. (1981), of the women who obtained abortions in 1978, one-third were teenagers, three-fourths were unmarried, and two-thirds were white. Additionally, the authors noted that 9% of the abortions were performed during the second trimester. The drop in the proportion of abortions by unmarried and nonwhite during 1977 and 1978 was thought by Henshaw et al. to be due to the 1977 Hyde Amendment which restricted the use of Medicaid funding from use for abortions. However, the

finding that a majority of women receiving abortions were white may relate to the findings of Granberg and Granberg (1980) which demonstrated that whites are more approving of abortion than blacks.

Many changes concerning abortion are still occurring even after a decade. As Smith (1982) stated, there is ambivalence in the United States regarding abortion in most of society, legislatures, the health care system, and in women and their significant others. Due to the ambivalence of society as a whole, it is important to examine psychological factors that may influence a woman with a problem pregnancy to decide to terminate that pregnancy.

Psychological Conflicts Related to Abortion

Many authors (Blumenfield, 1978; Brewer, 1978; Freeman, 1977, 1978) agreed that the decision to seek an abortion is stressful for any woman with a problem pregnancy and may be stressful for her partner and/or family as well. Studies have been devised to test speculations regarding psychological outcomes for women who have abortions. Since there is a wide diversity of conflicts in women seeking abortions, literature is reported as it relates to circumstances surrounding problem pregnancies, problems of adolescent pregnancies, delay factors in second trimester abortions, post abortion conflicts, and post abortion depression.

To determine the meaning of the pregnancy to the woman is a beginning step in understanding psychological conflicts related to abortion. In 1978, Blumenfield undertook an exploratory study to determine what circumstances surround a pregnancy for which an abortion is sought. He interviewed 26 randomly selected clients, half of whom were receiving first abortions and half repeat abortions. The women were questioned in the clinic for approximately an hour using an open-ended interview schedule. Data were expressed in percentages. The results showed that 34% of the women expressed conflict over having had a desire to become pregnant following a significant loss in her life. Additionally, it appeared that often there had been a strong desire on the part of the male partner to father a child. The conclusion drawn by Blumenfield was that the problem pregnancy was due to conflicts in either the female or male partner, and that problem pregnancies yielding requests for repeat abortions probably represented acting out of an unresolved conflict. He recommended counseling of both partners whenever possible and that the counselor assess with the client the circumstances surrounding the pregnancy.

Pregnant adolescents have special problems. Barglow (1976) wrote an opinion article on the psychological reactions of adolescent girls obtaining abortions. He cited

one of his own studies of 78 teenagers of varied ethnic and economic backgrounds who underwent abortions during the first trimester of pregnancy. The setting was a hospital abortion unit. No other information was given regarding the type of study, instrument, or treatment of data. He reported that the group showed a great deal of ambivalence regarding the abortion decision and that the majority viewed the abortion procedure as "frightening, dangerous, . . . punitive, and . . . temporarily overwhelming" (Barglow, 1976, p. 43). He also attempted to follow up 50 clients one to three months following their abortions, but only half of these girls could be located. Eighty-four percent of the 25 adolescents had adjusted well psychologically but reported having had experienced a multitude of psychic or somatic symptoms which were temporary and had limited severity. The remaining 16% expressed regrets and doubts about the abortion and 8% of these were severely depressed. Barglow concluded that adolescent girls must be more carefully screened in order to prevent adverse postabortion reactions.

The abortion client who presents during the second trimester brings special problems--both physically and psychologically. Brewer (1978) described a pilot study at two clinics involving 40 clients who were at least 20 weeks

pregnant and had felt quickening prior to their abortion. Some clients were personally interviewed during or after their abortions and others were interviewed by telephone. No information was given regarding the interview schedule. The purpose of this interview was to gain understanding of why the woman had not sought an earlier abortion. Data were expressed in percentages. The reasons for late abortions included denial (35%), history of significant menstrual irregularities (27.5%), and change in status of pregnancy from wanted to unwanted (15%). Other reasons included delays in obtaining abortions and misdiagnoses. These clients were followed up three months later to determine their postabortion physical and psychological conditions. Of 25 respondents, 20% reported depression related to their abortion but none sought psychological help. Twenty percent stated that feeling quickening made the decision to seek an abortion more difficult.

Kaltreider (1981) stated that the decision to obtain an abortion is more stressful for women seeking second-trimester abortions. He indicated that these are the women who may already be more fragile emotionally than those who seek early abortions.

Ketting (1982) summarized the reasons for late abortions found in five studies and divided them according

to three factors. The first dealt with pregnancy recognition and included denial of pregnancy, history of irregular menses, unfamiliarity with pregnancy signs, misdiagnoses, and use of a highly effective contraceptive. The second category were those elements associated with decision making and included ambivalence, fright, and sudden changes in circumstances. The third factor included conditions external to the patient, such as lack of knowledge regarding the location of the abortion clinic, physician delay in referral, and problems of a financial nature. Additionally, Ketting pointed out that the client who seeks a late abortion is characteristically extremely young or over 40, unmarried or married previously, living separately from her partner or with her parents, having either no or many children, and of low educational level and socioeconomic class. These factors contribute to ambivalence in reaching a decision regarding the problem pregnancy. Therefore, these women needed adequate counseling to allow resolution of conflicts (Ketting, 1982).

Postabortion conflicts often manifest themselves in emotional difficulties. Freeman (1977, 1978) published the results of a descriptive study done in 1975 at two outpatient clinics in metropolitan Philadelphia. This study was done using 329 conveniently selected clients who had

requested first-trimester abortions. Six percent of the women who were asked to participate in the study refused due to one of three reasons: they were "too upset"; they were hostile; they were unable to understand English. Two investigator-designed self-administered questionnaires were used to furnish contraceptive, attitudinal, and demographic information. No reliability or validity was reported for these instruments. One of the instruments was completed following the abortion experience and the second was mailed four months later to those 76% of the original subjects who had consented to follow-up. Of this group, 43% responded to the mailed questionnaire.

Results of Freeman's (1977, 1978) study, reported in percentages, indicated that ambivalence about the pregnancy continued after the abortion procedure. Most women experienced emotional conflict regarding the abortion. Twenty-four percent of the sample stated that the primary difficulty was dealing with the loss of a child. Another 14% replied that decision-making was the most difficult, while 11% stated that loneliness was the most difficult. Others listed problems such as waiting, fears of the unknown, physical pain, self-acceptance, and others.

Freeman (1977, 1978) stated that the four-months follow-up revealed 60% of the subjects had resolved their

feelings about the abortion, but 40% were still troubled or could not bear to think about their abortion. Freeman attributed most of the unresolved conflict to problems in the relationship with the male partner and/or personality attributes which suggested high levels of anxiety, extremely negative self-images, and avoidance or displacement of feelings. The author concluded that it appeared those women who originally chose not to participate in the study or those who did not complete the follow-up were those women who were experiencing the most emotional difficulties related to their abortions. Recommendations in the study included counseling of both partners and emotional support following the abortion. Additionally, Freeman advocated that counselors must keep in mind the influence of personality factors on ability to resolve the issue.

The incidence of postabortion depression was investigated by both DeVore (1979) and David, Rasmussen, and Holst (1981). Sim (1981) reported his findings on prognoses and postabortive psychoses. DeVore (1979) conducted a descriptive study to investigate whether there was a higher incidence of postpartum depressive reactions in women who had experienced previous elective abortions than for primiparas who had not experienced elective abortion. The convenience sample included 25 women who had a previous

abortion in the experimental group and 48 gravida 1, para 1 women in the control group. Six to eight weeks following delivery DeVore administered the Beck Depression Inventory Short Form to all the subjects in their homes. Reliability or validity were not reported for this instrument. The chi-square test indicated no significant difference between the group in the number of subjects experiencing postpartum psychosis (p=.39). The author noted that those clients with previous emotional disorders were screened out prior to the study which may have skewed the results.

A retrospective study within the Danish health system was done by David et al. in 1981. The purpose of the study was to determine whether the rate of admissions of Danish women to a psychiatric hospital was greater during the first three months postpartum or postabortion. Data were collected via computer linkage on 71,378 women who carried pregnancies to term, 27,234 women who terminated unwanted pregnancies, and 1,169,819 women who represented the complete female population aged 15 to 49. Results were reported in rates. The authors found that there was no difference between the rate of admission for currently married or never-married women who either obtained abortions or carried their pregnancies to term. David et al. also found that the rate of admission for women who were

separated, divorced, or widowed who had abortions was significantly higher than the rate of those who delivered. Additionally, they reported that women of all parities who obtained abortions were demonstrated to be at higher risk for psychiatric hospital admission than women who delivered. Their recommendations included special provisions in the counseling process for women who have been separated from their partners.

In Sim's (1981) essay on psychiatry and abortion, he cited one of his own studies on the prognosis of post-abortive psychoses versus postpartum psychoses. Very little information was given regarding the method of data collection and only his results were described. He studied clients in two psychiatric centers; one was in England and the other was in Israel. He found that prognosis was poor for only 1% of the clients with postpartum psychoses, while it was poor for 50% of the clients with postabortive psychoses. A poor prognosis meant that symptoms may not go into full remission, restoration to premorbid level functioning may not occur in an acceptable time frame, or that relapses might occur. The authors also stated that many women do not have such drastic psychiatric sequelae but that an abortion may often be a precipitating factor which results in psychotherapy. Additionally, he asserted that

statements regarding psychiatric sequelae immediately following an abortion were often erroneous since the psychoses often do not declare themselves until 6 to 12 weeks postabortion.

Most of the previously mentioned studies have demonstrated that there are many psychological aberrations to be addressed in dealing with the woman who has a problem pregnancy. How these psychological problems may be dealt with during the counseling process will be described in the following section.

Problem Pregnancy Counseling

In 1979, the World Health Organization published guidelines for abortion services. One of the components required prior to an abortion is counseling which also includes contraceptive advice. Although it is recognized that different situations and cultures require different emphases, the World Health Organization stated that there should be three features of abortion counseling: psychosocial support, information regarding the procedure itself, and counseling regarding the use of contraceptives.

The idea that counseling is an integral part of the abortion process is echoed by most authors (Baudry & Wiener, 1974; Bracken, Grossman, Hachamovitch, Sussman, & Schrier, 1973; Dauber, 1972; Rzepka, 1980; Scott, 1972). Definition

and goals of counseling, important factors to resolve, studies on different aspects of counseling, studies on factors influencing clients to carry to term, information on abortion counselors and training were found to be of importance in the literature.

Ness (1976) defined counseling as a process

> enabling the patient to make a decision for which she can accept responsibility, coupled with helping her to gain an understanding of how she came to be in her present situation and how she might avoid a repetition of her predicament. (p. 80)

The goal of counseling then was described by Kahn-Edrington (1979) as the mobilization of the woman's coping skills, reduction of the impact of individual factors in the situation, dissemination of information, and provision of support. Rzepka (1980) stated that through a careful process involving the above procedures the woman will be capable of arriving at a decision for which there will be greater self-understanding and fewer chances for regret.

Some important factors to be resolved are unique to abortion counseling; others apply to any crisis situation. The primary unique factor in abortion counseling is the pressure of time (Baudry & Wiener, 1974; Ness, 1976). Baudry and Wiener recommended one to two exploratory interviews prior to a decision being made by the client. This recommendation may be complicated by a long period of denial on

the part of the woman which thus results in a delay to seek counseling. Denial is a common problem in adolescent pregnancies and may continue even when the pregnancy is obvious to all others (American Academy of Pediatrics, 1979). Baudry and Wiener contended that denial often continues into advanced stages of pregnancy in women who experience conflict. Even if the woman seeks counseling early in pregnancy the time frame for decision-making is short in order to time the abortion during the first trimester. Denial and delay in seeking help increase the problem with time pressure.

Baudry and Wiener (1974) stated that the pregnant woman tends to be more dependent and passive and often will gladly relinquish the decision making role to an authority figure. Dunlop (1978) declared that it is very important for the adolescent to make her own decision regarding the pregnancy because if the decision is made for her, she will tend to retreat into a dependent position in which she is likely to deny her pregnancy or sexuality. According to Dunlop, this contributes to a cycle of future refusal of responsibility for contraception and pregnancy and leads to repeat abortions. Even though she stressed the importance of decision making by the woman, Dunlop also stressed the importance of interviewing the significant people in the life of the

pregnant woman. The purpose of this is to clarify hidden conflicts as opposed to airing their opinions regarding the resolution of the pregnancy. Addelson (1973) also asserted that the opportunity to make the decision while having strong ego support helps to guide a woman towards healthy future crisis resolution.

Another factor cited by Baudry and Wiener (1974) is that often the purpose of the pregnancy appears to be the alleviation of a sense of personal loss. This applies only to the state of being pregnant and not to the meaning to the client of having a baby. This needs to be brought to the attention of the client in order for resolution of this conflict.

Fear of physical pain from the abortion procedure itself is another variable to be dealt with in abortion counseling. Bracken (1977) stated that accurate admonitions regarding possible discomfort that may occur during the procedure enable the woman to cope better with any pain she experiences.

Different aspects of counseling have been studied by many authors. Dauber, Zalar, and Goldstein (1972) conducted an exploratory study of an abortion counseling program at a hospital abortion center. Success was measured by the number of women who returned for postabortion checkups

and the number of women who began and then continued contraceptive use. The subjects consisted of two groups of 99 abortion clients respectively who were chosen by convenience. Group I was given a 10 minute lecture on contraception by a nurse who had no other contact with the clients. Group II received counseling and assistance from the same abortion counselor during the entire clinic experience. There was no instrument used; however, patient records were used to obtain demographic data, the numbers who returned for postabortion checkups and continued contraception for six months. There was no level of significance given but it was stated that the counseling experience was beneficial since 90% of the women counseled returned for checkups and contraception as opposed to only 60% of those who were not counseled.

An exploratory study reported by Marcus (1979) was intended to test five counseling goals. The nonprobability sample was derived from clients receiving abortions at Vancouver General Hospital who were referred to the study by a participating physician and who expressed a willingness to participate. The clients were assigned to either the counseled or non-counseled group in an alternate fashion. The final sample included 401 clients in the counseled group and 404 in the non-counseled group. Three self-administered

questionnaires were given at different times: the first was given after seeing a counselor but 10 to 14 days prior to the abortion; the second was mailed five weeks after the abortion; the third was mailed out six months after the abortion. The content of the questionnaire, sample of questions, report of pilot testing, reliability and validity were not divulged. Results of Marcus' study were given, but there was no level of significance or type of statistical test reported. Each goal and the reported results are as follows.

The first goal (Marcus, 1979) was to inform clients regarding reproduction and contraception. The counseled group of clients demonstrated greater knowledge of reproduction and contraception both before and six months following their abortions. Goal two was to decrease repeat abortions through strengthening contraceptive use. Each group showed an increase in the use of contraception and the groups demonstrated no difference in the repeat abortion rate. The third goal was to assure consideration of alternatives to abortion. It was found that there was no difference between groups in consideration of alternatives. The fourth goal was to decrease negative feelings associated with the abortion. The non-counseled group reported more depression prior to the abortion but this leveled out after the abortion

until there was no difference between the groups. The only way in which the counseled group consistently scored higher was in satisfaction with their decision. The fifth and final goal of Marcus' study was to increase attendance at medical follow-up. There was no difference demonstrated between the groups in this aspect. Although counseling did not help to meet some of the above goals, it was perceived by Marcus that the program was effective in offering emotional support during decision making.

An exploratory study by Bracken et al. (1973) focused on measuring the effectiveness of three techniques for counseling at an abortion clinic. The sample consisted of 489 successive abortion clients who were randomly assigned to one of three types of abortion counseling: group orientation, group process, or individual counseling. Group orientation consisted of a 30 minute didactic presentation of the abortion procedure, postabortion precautions, and contraceptive methods. Group process involved an hour long presentation of the elements in group orientation plus group discussions of social and psychological issues related to abortion. Individual counseling was a discussion for 30 minutes between counselor and client regarding the abortion procedure, birth control methods, and the primary needs of each client.

Each of the participants in Bracken et al.'s (1973) study was given three self-administered questionnaires at specific times during the process. The first questionnaire consisted primarily of demographic information plus a few questions regarding relationships with the sex partner and/or parents, the client's first reaction to the pregnancy, and factors which had influenced the client to seek an abortion. This tool was completed prior to assignment to a counselor or method of counseling. The second questionnaire was administered immediately after counseling but prior to the abortion. This was to measure the client's reaction to the counselor, the counseling technique, and the client's preparedness for the procedure. The third questionnaire was administered in the recovery room following the abortion. The intent of this was to measure the client's overall reaction to the experience. The questionnaires were described and some examples of items were given in the article. However, there was no discussion of pretest, reliability or validity for any of the instruments.

Bracken et al.'s (1973) study results were reported using a level of significance which varied from $p<.001$ to $p<.007$ depending upon what was being measured. It appeared that several statistical tests were done on the data but they were not listed. The women who experienced individual

counseling generally reacted in a more positive fashion to the counseling procedure than those who experienced other types of counseling. However, those who had been counseled by group process had greater satisfaction to the overall abortion experience. Experiences varied according to age group. The older women had the most positive reaction to the abortion regardless of type of counseling but reacted least favorably to the group counseling, whereas younger women reacted most favorably to group counseling. Bracken et al. recommended that centers with large numbers of young women consider group counseling.

Studies have been done to delineate factors which influenced clients to drop from an abortion clinic and carry their pregnancies to term. Swigar, Breslin, Pouzzner, Quinlan, and Blum (1976) conducted an exploratory survey to identify factors which caused a client to change her mind after considering an abortion seriously enough to have come to an abortion clinic. The convenience sample consisted of 27 former clinic patients who were interviewed by telephone using an unstructured format. The responses were then recorded on a checklist which included interpersonal, intra-personal, and environmental variables. There was no reported pretest of the interview schedule. The results were reported in percentages. Factors reported to affect

withdrawal from the clinic included opposition based on moral or religious reasons, desire of sexual partner for a baby, fear regarding the abortion procedure, incentive for marriage, and rebellion against family wishes. Swigar et al. recommended that each woman contemplating an abortion be given an opportunity to be counseled in regard to conflicts she might be experiencing.

Swigar, Quinlan, and Wexler (1977) conducted an exploratory study in which records of 200 women were examined to answer three questions: (1) What were the distinguishing demographic characteristics between women who have an abortion and those who carry to term? (2) Which person influenced the woman in the decision of whether or not to have an abortion? (3) Were there other indicators distinguishing those who have abortions from those who carry to term? Each of the two nonprobability groups in the sample consisted of 100 clinic clients who either obtained an abortion or carried their pregnancies to term. Later, their charts were disguised as to the outcome of the pregnancy and rated by a member of the investigating team in regard to feelings of the sexual partner, abortion fears and feelings, the amount of expressed indecision, and expressed moral or religious objections. The rater speculated as to the outcome of the pregnancy. Data were tested using

either Chi-square or t-tests at a level of significance of $p<.05$ or better as appropriate.

The results of Swigar et al.'s (1977) study included the following significant findings. Both the women who had abortions and their sexual partners had more education than their counterparts who carried to term. Twenty-two percent of those who had abortions presented for medical care after 12 weeks gestational age as opposed to 38.9% of women who carried to term. Additionally, those who carried to term were found to have greater fear of the abortion procedure, fewer negative feelings regarding the pregnancy, more indecision, and more negative feelings about abortion often expressed in terms of "murder" or "something sinful" ($p<.05$). Their partners also expressed more negative feelings about abortion. Swigar et al. found no significant difference between the groups in terms of current marital status or plans for marriage, divorce, or separation. These findings were contradicted by David et al.'s (1981) previously discussed research. Research of their study led Swigar et al. to recommend counseling that uses decision making theory for women with problem pregnancies.

A profile of abortion counselors in the San Francisco Bay area was provided by Dauber (1974). She conducted an exploratory survey of 100 counselors from randomly selected

hospitals, clinics, public health departments, self-help groups, university clinics, and various referral agencies. No information was given about the questionnaire, pilot testing, reliability, or validity, and the data were reported in percentages.

According to Dauber (1974), 96% of the counselors were women. Of these, 20% had had abortions themselves, 50% were married, and 85% reported that they were using some form of birth control. Of these counselors, 75% were between ages 21 and 31, and 65% had no children of their own. Dauber noted that it was not surprising that most had been in the counseling position for less than 2½ years since the job was a fairly new one at that time.

All of the counselors in Dauber's (1974) study were high-school graduates and 33% had some type of nursing background. The nursing background ranged from RN to nurse-practitioner to Master's of Science in nursing. Seventy-five percent of the counselors had a baccalaureate degree in some field and 22% had master's degrees, primarily in nursing, social work, or public health. None of these counselors had received formal training for this job, but 4% had attended training workshops on abortion counseling. Seventy-five percent of the counselors did personal interviewing most of the day. All did individual counseling, but

one-third of these also did group counseling. After reporting her findings, Dauber recommended that standards for abortion counseling be set and a training curriculum be established. Similarly in 1974 the Council on Resident Education in Obstetrics and Gynecology and the American Association of Obstetricians and Gynecologists Foundation (Lindheim & Cotterill, 1978) recommended that training for residents should include abortion counseling, the abortion procedure, and treatment of abortion complications.

In 1978, Lindheim and Cotterill completed an exploratory survey of 438 hospital-based residency programs in obstetrics and gynecology to determine the extent to which the above recommendations were incorporated into the curriculum. The survey was reported to deal with four areas: observing an abortion, performing a first-trimester abortion, performing a second-trimester abortion, and treatment of abortion complications. The tool was devised by the authors with no indicated pilot test, reliability, or validity. The responses were given in percentages.

The results of Lindheim and Cotterill's (1978) survey indicated that there was a wide scope of requirements for residents which varied from refusal to allow the resident to participate to requiring resident participation in each of the four areas. The surveyed residency programs'

requirements in the four areas were reported as follows: (1) observing an abortion--was required by 40% of the programs and 50% offered it as an option; (2) performing a first-trimester abortion--was required by 26% of the programs and 7% denied this experience; (3) performing a second-trimester abortion--was required by 23% of the programs and 16% denied this experience; and (4) treatment of abortion complications--was required by 90% of public hospital programs, but 25% of Catholic hospital programs did not offer this. Lindheim and Cotterill recommended that abortion related curriculum standards be established for training of physicians. However, they did not specifically address the issue of counseling.

There are many factors to be resolved during the counseling process, but little formal training appears to be available for counselors. Additionally, Dauber's (1974) study demonstrated that nurses are often involved in counseling and Smith (1982) stated that nurses may also be involved in direct care during the abortion itself or during care following a complication. Thus, the literature was reviewed for implications for nurses who care for clients that seek abortions.

Nursing Implications

It is difficult to discuss implications for nursing without addressing the topic of attitudes about abortion, since this has been a primary focus in much of nursing literature (Harper, Marcom, & Wall, 1972; Olson, 1980; Smith, 1982). Smith (1982) stated that abortion has caused conflict for health providers because this procedure was illegal only 15 years ago and health providers are expected to never refuse care--even when it compromises the moral standards of the provider. Additionally, health providers are expected to treat clients with a nonjudgmental attitude which, according to Smith, is a feat that is not accomplished in many abortion situations.

Throughout the decade from 1973 to 1983 research and opinion articles have dealt with differing aspects of affects of nurses' attitudes regarding abortion. The roles of nurses in abortion have been described as those of counselor, direct caregiver, or both during or following the abortion. These roles, however, have only been recently developed because abortion was illegal until 1970.

One of the earliest groups to begin developing nursing roles for abortion care was nurses in New York. In 1970, legislation was passed which allowed the physicians and client to make decisions regarding abortion. Smith,

Veolitze, and Merkatz (1971) described the combined work of nurses and social workers to meet the needs of the whole person who came to the newly formed Family Planning Abortion Clinic at The New York Hospital. The article dealt with how psychosocial needs were met through a preabortion group counseling session which was led by either a social worker or a nurse. The goals of these sessions were to orient the clients in terms of what to expect medically and to allow them to explore their feelings regarding the abortion. Nurses shared technical information regarding medical procedures and helped clients to gain trust and confidence in the staff who cared for them. Other functions included discussion of contraceptives and preoperative instruction. Smith et al. stated that the opinion of the staff was that the program appeared beneficial to the clients.

Harper et al. (1972) conducted a descriptive study to determine the relationship between nurses' attitudes towards abortion and the patient's perception of the quality of care. The study involved three groups in each of two Denver area hospitals: caregivers, abortion patients, and nonabortion patients who were chosen by nonprobability method. The total sample included 97 caregivers (registered nurses, licensed practical nurses, and aides), 63 abortion patients, and 55 nonabortion patients. Two different types

of measurements were obtained and then compared. The Sherif-Havland nine-statement ordered alternatives were given to the caregivers to measure their attitudes towards abortion. There were no reliability or validity data reported for this instrument. The patients' perception of care was measured with a Likert-type instrument. The authors did not designate the origin of this instrument, its reliability or validity. The analyses involved two-way analysis of variance and t tests at $p \leq .05$. The results of this study indicated that the caregivers in Hospital One had less favorable attitudes towards abortion and that abortion patients in this hospital had a significantly more negative perception of their care than the nonabortion patients. Additionally, the nonabortion groups of both hospitals were compared in order to rule out other causes for this difference. The two nonabortion groups did not show a significant difference. The authors recommended that nursing education help nurses to develop insight into their personal attitudes and the effects of their attitudes upon their behavior with others.

As was stated earlier, Dauber (1974) revealed that 33% of her sample of abortion counselors were nurses. Easterbrook and Rust (1977) also indicated that abortion counseling is done by nurses and they described the tasks

that nurses accomplish as abortion counselors in a hospital abortion center. These tasks included educating about the medical procedure, teaching simple anatomy and physiology, giving after-care instructions, instructing about birth control, discussing female sexuality, explaining counseling program to interns and residents, and contributing to staff development.

In 1978 Estok described abortion attitudes of student nurses. This study had a pre-course/post-course design in which 81 conveniently selected senior nursing students participated. The setting was not stated. The author hypothesized that students would have a more positive attitude regarding abortion prior to, rather than after, clinical experience, that attitudes of the students would become more negative toward abortion after viewing a 12 to 24 week fetus which had been aborted, and that nursing students with high religiosity scores would become more negative toward abortion than students who scored lower on the religiosity scale.

An instrument was designed for the Estok (1978) study by using questions on religious orthodoxy from various sources including Putney-Middleton and Wilke. The questionnaire was pretested on five subjects, but no reliability or validity were presented. Data were analyzed using *t* tests

at p = .005 and p = .0005. All three hypotheses were rejected since the subjects became significantly more favorable towards abortion following clinical experience. Estok advocated abortion clinical experience for nursing students in order to reduce negative attitude toward abortion.

In 1980, two articles again demonstrated that the attitude towards abortion was still a thorny issue for nurses (Olson, 1980; Sandroff, 1980). Although RN magazine is an unrefereed journal, the following article was included to show a theme in nursing. Sandroff (1980) reported on an exploratory survey done by RN magazine in which 12,500 nurses responded. The instrument was an ethics survey by RN, but no other information was reported regarding it. Educational level of the sample of nurses was not described. Data were reported in percentages. The results indicated that approximately 70% of the sample agreed that abortion was appropriate for medically indicated reasons or rape and 44% of the sample advocated abortion for any unwanted pregnancy. Twelve percent of the sample stated that abortion is never permissible.

Also in 1980, Olson examined factors which contribute to conflict in nurses over abortion. She stated that these conflicts often surface in hostile or punitive attitudes or

actions toward abortion patients. Enumerated as factors that often caused conflict were philosophical conflicts regarding the beginning of life, conflicts regarding the view of motherhood, conflicts relating to human rights, overidentification with the fetus, and conflicts related to client reaction to the abortion. The author recommended specific steps to be undertaken in inservice, nursing administration, and nursing education to help nurses deal with and resolve these conflicts. Olson stated nurses must deal with and resolve conflicts because over a million abortions occur every year and nurses will encounter abortion clients in clinics, hospital wards, and emergency rooms.

Admire and Byers (1981) described the counseling role of nurses in giving care to teenagers. They stated that it is the responsibility of nurses to suggest in a nonjudgmental fashion alternate courses for resolution of the problem of pregnancy. The authors also declared that nurses can be very helpful by preparing the adolescent to confront her parents with the news regarding her pregnancy. Admire and Byers considered the counseling role of the nurse a very important role.

In Smith's (1982) book, a chapter was devoted to attitudes and actions of the providers of health care. Smith traced the history of nursing and discussed the

conservative attitude of most nurses towards abortion. She alleged that nursing education must change in order to adequately prepare nurses for these roles by recognizing abortion as a legitimate surgical procedure, teaching content relating to physiological and psychological aspects of abortion, and training students in counseling techniques.

The literature indicated the role of the nurse in abortion counseling and care is still being refined and is still fraught with conflicts. Therefore, crisis intervention theory and postulates for decision-making can provide an underlying foundation for aiding the nurse in abortion counseling.

Crisis Intervention and Decision-Making

Scott (1972) pointed out that a situation of crisis proportion may result from a problem pregnancy. The pressure of time was seen as the factor which precipitated crisis in either the woman or the couple. This view concurs with Caplan's (1964) statement that crisis occurs because the problem is large and unable to be solved within a particular time frame.

Crisis was described by Morley, Messick, and Aguilera (1967) as temporary instability resulting from some unexpected event. The individual is not able to resolve the instability by using normal coping mechanisms and therefore

suffers anxiety and depression. As anxiety increases, perceptual awareness narrows and the individual only focuses on the difficulty. This results in the individual not being able to make use of past experiences and puts the person further from the solution to the problem (Aguilera & Messick, 1982). It is at this point, according to Morley et al., that the person is ready for major change and is amenable to short term help by someone else.

The steps of crisis intervention were outlined by Morley et al. (1967) and Aguilera and Messick (1982). These steps are described as they pertain to the woman with a problem pregnancy.

1. Assessment: In this phase the counselor attempts to obtain much information about the woman and her pregnancy. The information sought includes the following: her level of anxiety, the meaning of the pregnancy, her view of its effect to her future, her available situational supports, and the woman's usual coping skills. It also includes whether she is suicidal and whether her view regarding the pregnancy is realistic.

2. Planning intervention: In this phase a determination is made regarding the disruption of the life of the woman. The effects of the pregnancy upon the relationships with her significant others are evaluated. The

question of why the pregnancy occurred is examined. Then alternative solutions are considered and weighed according to past experience and within the context of the present circumstances.

3. Intervention: In this phase the intervention is initiated. Abortion would be considered to be an intervention.

4. Anticipatory planning: In this phase the client and the counselor meet again to determine whether or not the crisis has been resolved. This phase also includes help in making realistic plans for the future and plans to avoid future crises (problem pregnancies).

Morley et al. (1967) described the role of the crisis intervention counselor as being an active role while not necessarily directive. They stated that this role is very flexible and may include serving as a resource person, information giver, or a liaison between the client and other resources.

Bracken (1977), citing an earlier work of Janis and Mann, stated that abortion counseling involves decision counseling and recommended that abortion counselors teach some of the basic tenets for making quality decisions. He contended that teaching basic tenets improves the decision making process as opposed to influencing the decision choice.

Janis and Mann (1982) concurred with Bracken's (1977) statement regarding the purpose of decision counseling. The authors cited stress and superficial information searches as reasons for many poor quality decisions. They stated that decisional conflict arises from simultaneous opposing tendencies within an individual to accept or refuse a course of action and that people typically use one of five coping patterns to resolve the conflict.

The five coping patterns described by Janis and Mann (1982) are briefly listed as follows: (1) "Unconflicted adherence" (p. 51). The decision maker ignores risk of losses and continues the present course of action. (2) "Unconflicted change to a new course of action" (p. 51). A new course of action is uncritically adopted according to what is most strongly recommended or the most conspicuous option. (3) "Defensive avoidance" (p. 51). The decision maker procrastinates, shifts responsibility to another person, or uses rationalizations to filter out correct information in order to escape the conflict. (4) "Hypervigilance" (p. 51). The decision maker searches frantically for an alternative and overlooks the full range of consequences in order to receive immediate relief through a hastily contrived solution. (5) "Vigilance" (p. 51). The decision maker carefully searches for information and

evaluates each option in an unbiased manner before making a choice. Janis and Mann contended that only vigilance leads to high quality decisions with little regret. Vigilance is accomplished by thoroughly canvassing a wide range of alternatives, carefully weighing the positive and negative consequences of each alternative, searching for and evaluating new information in an unbiased fashion, reexamining positive and negative consequences, and making detailed plans for the chosen course of action and contingency plans for the possible materialization of known risks.

Additionally, Janis and Mann (1982) recommended that the counselor use a structured interview to obtain the client's explanation of the decisional dilemma and to aid the client in making a choice. The authors stated that the counselor must renounce the role of the authority figure but should strongly recommend a thorough appraisal of all alternatives. They also advocated helping the client to use a decisional balance sheet. The balance sheet will help evaluate each course of action's positive or negative effects to the client and significant others as well as anticipated approval or disapproval to self and from significant others. The authors recommended counselors do all that is possible to help their clients avoid defective coping patterns. The authors also contended that the more defects present during

the decision making process, the greater the chance for postdecisional regret.

Baudry (1974) stated that there may be subtle clues available to the counselor that may indicate the client has not truly resolved the conflict even though a decision was reached. These clues may include depression, inability to sleep, multiple vague somatic symptoms, increased irritability or moodiness, or expressed feelings of pressure from her family. He noted that in this case the decision and alternatives need to be reexamined.

There have been several studies relating to factors affecting decision making in women with problem pregnancies. In 1975 Bracken and Kasl conducted an exploratory retrospective study designed to identify factors in the decision making process which result in delayed decisions to seek an abortion. The sample consisted of 345 women seeking either a first or repeat abortion over a 5½ month period at a clinic. The self-administered questionnaire included demographic, social, and pregnancy information and variables measuring psychological and interpersonal factors influencing the decision to seek abortion. There was no report of pretest, reliability, or validity for this instrument; however, some of the questions from the questionnaire were repeated in the article in order to demonstrate how some

variables were measured. Data were analyzed using path coefficients. A significance level of $p = .1$ was reported for the repeat abortion group. However, a significance level for the first time abortion group was reported to be $p<.01$. Significant findings indicated that women having their first abortion were less likely to have anticipated pregnancy, less likely to have perceived the missed menstrual period as a sign of pregnancy, denied their pregnancy longer than the repeat abortion group, and shared information regarding their pregnancy with more people. The authors summarized their findings by stating that delay appears to be related to suspecting and acknowledging pregnancy rather than psychological reactions to the decision itself.

Fischman's (1977) retrospective nonexperimental study was conducted in order to identify personal and social characteristics which differed between the pregnant unmarried adolescent who had an abortion and the one who chose to have her baby. The population consisted of 229 black adolescent girls chosen by convenience method from the caseload at a city health department maternity and infant project. Each participant was interviewed and several months later charts were reviewed to ascertain which women had changed their original decision. Little of the content

of the interview was described by the author, nor were treatment of the data and significance levels reported.

Fischman (1977) listed the major reasons given for either decision. She reported that reasons for choosing delivery were desire for a baby, moral reasons against killing the fetus, pressure from a mother or a boyfriend, and fatalistic reasons. Reasons given for choosing abortion were young age, economic reasons, school interference, and pressure from family or boyfriend. Other findings indicated that deliverers tended to have greater emotional support from their parents than did those who sought abortions; the decision making process frequently was influenced by the relationship between the woman and her boyfriend; the family more often influenced the woman obtaining an abortion, whereas the boyfriend more often influenced the deliverer; and attitudes of the woman regarding abortion influenced the outcome of the decision. Fischman concluded that low-income teenagers perceived motherhood as an avenue to recognition and status and that the decision process was affected by family and boyfriend pressures, personal attitudes and goals, and economic factors.

In 1978 Fielding, Sachtleben, Friedman, and Friedman reported on their exploratory nonexperimental study which examined reasons for delay in seeking abortions. The

nonprobability sample consisted of 697 women who sought abortions in three types of settings: private practice, a hospital clinic, and a free-standing abortion clinic. The researchers used personal interviews to ascertain reasons for abortion and for delays in seeking abortion. No information regarding the form of interview was reported. Data were treated using the coefficient of determination or the *t*-test using levels of significance varying from $p = .01$ to $p = .00001$. Findings indicated that delay was most prevalent in young, unmarried, and minimally educated women. The most common reasons given for delay were fear, ambivalence, and denial. Those three reasons accounted for nearly 50% of the clients' delay. Another 18% of the clients listed failure to recognize the pregnancy due to previous irregularity in menstruation. Fear and ambivalence were seen more often in the less educated client, whereas denial occurred more often in the client with a higher level of education. Fielding et al. recommended that information, education, and support should be targeted to the young, unmarried, minimally educated women in this country in an attempt to decrease the impact of fear which results in delayed decision making.

Bracken, Klerman, and Bracken (1978) conducted a retrospective study using two matched groups of women at a

hospital clinic to describe the process of decision making in the resolution of a problem pregnancy. The two groups consisted of never-married women who chose either to deliver or to have an abortion. The women were individually matched on parity, welfare status, and race. The subjects were young, three-fourths of them black, and two-thirds were on welfare. A self-administered questionnaire was used; then an interview followed in order to review the answers on the questionnaire. No report was given regarding a pretest of the questionnaire, its reliability, or its validity. Examples of questions were given in the article to demonstrate how variables were measured. Data were analyzed using the chi-square or the t test as appropriate with significance levels varying from $p<.05$ to $p<.001$. Significant findings included the following. Women who were delivering had long term sexual relationships with their partners, used contraception less often than those seeking an abortion, and more often used contraceptive methods requiring mutual cooperation between partners. They also did not consider adoption as an option and were likely to have discussed their pregnancies with all categories of significant others. Women delivering stated that they received most support from their best girlfriend and their partner. Women opting for an abortion claimed most support from their

physician and best girlfriend. Some of the women who sought abortion reported persuasion for this course of action from their mother, girlfriend, partner, and physician. Bracken et al. concluded that the decision regarding the outcome of a problem pregnancy relates to the situation surrounding the pregnancy and not to characteristics of the pregnant woman.

In a longitudinal study, Rosen, Benson, and Stack (1982) attempted to examine how often parents know about their daughter's pregnancy, the degree to which they exert pressure, and the basis of parents' power for the pregnant teenager. The study was conducted in the offices of private physicians in a rural area. The nonprobability sample consisted of 100 women under 20 years of age. The sample was 98% white and 66% chose abortion. Of those in the sample who were unmarried, 12% chose to stay single and keep the baby, and 17% chose to marry and keep the baby. The remaining 5% of the sample were already married. During interviews of the sample, the researchers probed relations between daughter and each parent and the influence of significant others on their decisions. A self-administered questionnaire was given to explore attitudes about sexual activity, authority, gender roles, and self-concept variables. No other information was reported regarding

the type of interview or reliability and validity of the questionnaire. Data were reported in percentages.

The findings of Rosen et al.'s (1982) study related to four types of pressure or influence upon the daughter's choice: direct pressure, indirect pressure, direct influence, and indirect influence. Direct pressure was defined as the use of resources to influence the decision; only 11% of those who sought abortions stated that their parents did this to influence their decisions. Indirect pressure was described as anticipation that resources might be used as a weapon; 55% of those who chose abortion reported this type of pressure. Direct influence meant that advice was given without coercion to choose any alternatives; 24% of those who chose abortion and 44% of those who kept their babies reported this type of parental influence. Indirect influence essentially was considered to be role modeling or the nature of the woman's relationship with one or both of her parents. Of those who elected to marry and keep the child, 33% reported that their mothers had done the same. Nine percent of the married group also reported leaving home due to poor relationships with parents. Rosen et al. concluded that counselors could inform teens with problem pregnancies that parents are typically supportive during the decision making process.

Summary

Scope of abortion changes in the United States reported changes in laws and services during the last decade. Psychological conflicts related to abortion were described using studies which investigated circumstances surrounding problem pregnancies, problems of adolescent pregnancies, and delay factors involved in second trimester abortions. Additionally studies relating to postabortion affects were discussed. Problem pregnancy counseling described factors to be resolved in counseling and studies relating to counseling. Abortion counselors and their training were described. Nursing implications demonstrated the concerns of nurses and the emergence of nursing's role in all aspects of treatment of the abortion patients. The basic tenets of crisis intervention were presented in steps. Decision making approaches were described and explained, while studies which identified influencing factors on decisions were reported.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This descriptive survey of abortion counselors was conducted by mail. A descriptive survey, according to Polit and Hungler (1978) is "that branch of research that examines the characteristics, behaviors, attitudes, and intentions of a group of people by asking individuals belonging to the group . . . to answer a series of questions" (p. 206). In this self-administered survey actual counseling behaviors of abortion counselors were identified. A summated rating scale in assessment and planning intervention phases described frequency of adherence to recommended steps.

Setting

The setting consisted of 56 abortion clinics in Texas which were either on the approved list of the National Abortion Federation or advertised in the Yellow Pages of metropolitan area phone books in Texas. If advertised in the Yellow Pages, they were selected according to terms "abortion" or "termination of pregnancy" in their advertisement.

Population and Sample

The population from which the nonprobability convenience sample was derived was abortion clinic counseling directors or clinic counselors in Texas. The target population was clinic counselors in 56 abortion clinics. When the clinic was listed by National Abortion Federation, the survey questionnaire was mailed to the named director of counseling. For other clinics the survey was directed to the clinic counselor. The sample were those 56 abortion counselors from 26 abortion clinics who completed and returned the questionnaires.

Protection of Human Subjects

Approval to conduct the survey was obtained from Texas Woman's University. The instrument package mailed to each subject contained an introductory letter, the instrument, and a demographic data sheet. The letter (Appendix A) stipulated that participation was voluntary and requested that no names be written on the questionnaire to assure anonymity. The letter also explained that consent for participation in this study was evidenced by the completion and return of the questionnaire. The return envelope was coded to allow the researcher to follow up if needed on unreturned questionnaires. Upon return of the questionnaire, the subject's name was deleted from the master list and the

return envelope was destroyed. After the data collection, confidentiality was further maintained by destroying each returned questionnaire. Results were reported in group format only.

Instrument

No instrument was available that adequately measured the counseling behaviors of abortion counselors. Therefore the investigator developed an appropriate instrument, The Zotti Abortion Counselor Behavior Tool (Appendix B).

The procedures for developing the instrument included the following: (a) current literature review and identification of appropriate counseling behaviors for abortion counselors; (b) development of items and format for a measurement scale; (c) validation of the questionnaire by panel review; (d) pretest of the questionnaire for reliability; and (e) revision of the questionnaire. The questionnaire was examined for content validity and reliability in steps c and d, respectively.

The first step involved a search of literature which identified counseling behaviors in these stages of crisis counseling: assessment, planning intervention and resolution of the crisis and anticipatory planning. In the assessment phase the counselor is trying to establish baseline information on the client: How long did the client

cling to denial? What does the pregnancy mean to this woman? How does she see this pregnancy affecting her future? How has it affected her relationship with her sexual partner? What is her knowledge regarding contraception? Is she suicidal? How does she usually make difficult decisions? Who influences her most?

In the planning intervention phase the counselor and the woman review all available options and the woman makes a choice. In this stage the counselor assesses: Is the woman realistically evaluating all options? Is this truly her own decision? Does she need to refine her decision-making skills? Has she made plans for emergency care in the event of complications? Does her somatic presentation indicate that her decision is right for her? In this phase the counselor also gives factual information on each option as well as education on family planning methods.

In the resolution phase the counselor follows up to determine coping mechanisms and current use of family planning methods (Aguilera & Messick, 1982; Baudry & Wiener, 1974; Bracken, 1977; Dunlop, 1978; Scott, 1972). General criteria statements were also included in this phase. These measure the usual number of counseling sessions, the timing of these sessions, and the technique for counseling.

During the second step statements were developed to describe counseling behaviors which would be involved in the first two phases of abortion counseling. A Likert-type scale with statements ranked from always to never was the response format of this part of the questionnaire. A category "Not applicable" was also included. These two sections yielded ordinal level data.

The third step consisted of submitting the items to a panel of experts to be evaluated for content validity (Appendix B). The experts consisted of members of National Abortion Federation who teach counseling seminars and maternal-child nursing faculty at Texas Woman's University. Five of seven respondents stated that each item measures usual abortion counseling behaviors. Both other respondents did not respond to this question, but one of these wrote comments relating to time limitations on abortion counselors. It appears that this expert may have perceived the behaviors listed as too comprehensive to fit into time realities at abortion clinics. The panel members were also asked if they agreed with the category placement of each item. There was 100% agreement by experts regarding the placement of each item. From the pool of items on which consensus of the panel was reached, 32 items were selected to represent the scope of abortion counseling behaviors. The selected

items were distributed across the previously discussed three categories.

The instrument was pretested to evaluate it for reliability and clarity. The pretest was given to two members of National Abortion Federation and five maternal-child nursing faculty members at Texas Woman's University. Cronbach's coefficient alpha was used to establish reliability of the questionnaire. Reliability was calculated separately for each of the first two segments in both the pretest and the study. Reliability for Part I (Assessment) was .82 and .86, respectively. Reliability for Part II (Planning Intervention) was .73 and .87, respectively. Respondents were also asked to point out unclear items. Three respondents stated that all items were clear; one did not respond; and three listed items which were unclear. Items were either eliminated or reworded according to these responses. The pretest also indicated which statements were likely to be answered "Not applicable." These items were also deleted. Part III was revised to collect descriptive data only.

Following the pretest the questionnaire was revised into final form (Appendix C). Statements were eliminated in which the majority of the pretest sample answered "Not applicable." The final form consisted of 32 items which

represented the three categories: assessment, planning intervention, and general criteria and follow-up. In the first two phases the subjects responded to a Likert-type scale ranging from "Always" to "Never." The scoring scale was changed. Scoring for sections one and two of the questionnaire was as follows: (1) in positive statements Always = 5, Usually = 4, Occasionally = 3, Seldom = 2, and Never = 1. (2) In negative statements Never = 5, Seldom = 4, Occasionally = 3, Usually = 2, and Always = 1. The higher scores indicated agreement with recommended steps to aid decision making.

The third section of the instrument dealt with general criteria and follow-up behaviors. This section contained closed-ended statements regarding usual behaviors and was intended to yield descriptive data only.

The final section of the instrument contained the demographic data questions. The participants were asked to identify age, sex, marital status, currently pregnant, have children, use of birth control method, length of time counseling, highest educational attainment, receipt of training courses for abortion counseling, and whether or not they had had an abortion.

Data Collection

Data were collected at two different times. The study was preceded by a pilot study to test the instrument.

Pilot Study

The Zotti Abortion Counselor Behavior Tool (Appendix B) was distributed to nine experts from National Abortion Federation and Texas Woman's University maternal-child nursing faculty. Seven questionnaires were completed and returned.

Content validity of the instrument was established through evaluation sheets. Reliability from the pilot study for Part I equaled .82 and for Part II equaled .73. Unclear items were either reworded or eliminated. Items were individually analyzed and those with a minus discriminative power were eliminated. The number of items in Part I and Part II were made equal in order to be compared using the Wilcoxin matched pairs. The Likert scoring system was changed in order for respondents to more clearly discriminate between categories. Part III was reworked in order to obtain descriptive information only. The demographic data sheet remained the same.

Study

Upon approval of Texas Woman's University the investigator began data collection. The final form of the Zotti Abortion Counselor Behavior Tool (Appendix C) was mailed to directors of counseling or clinic directors of abortion clinics in Texas. They were asked to distribute the questionaire to all of their counselors. The counselors were instructed to answer the questionnaire, complete the personal data sheet, and return the questionnaire within three weeks to the investigator in the enclosed self-addressed envelope. Since an insufficient number of questionnaires for statistical purposes were returned, the investigator referred to the master code list and mailed follow-up questionnaires to those participants who failed to return the first questionnaire.

Treatment of Data

Each section of the instrument was scored independently. Research question one asked: Do abortion counselors adhere to recommended steps to aid their clients in decision-making? The rating scales in sections one and two were summed and described. The measure of central tendency, variability, and percentages were used to describe these data. The 95% confidence interval was used to measure adherence to recommended counseling steps.

Research question two dealt with which of the first two phases of counseling, assessment or planning intervention, yielded higher scores for the abortion counselors. These data were tested using the Wilcoxon matched pairs test for related measures.

Research question three asked how often abortion counselors did follow-up on their clients after the abortion. This section was described by using frequency distributions and percentages. The measure of central tendency and variability were also expressed.

Demographic data were also expressed in descriptive statistics. Additionally, the measures of central tendency and variability were used.

Summary

With the rapidly growing number of women in the United States having abortions, it is important to identify what behaviors abortion counselors exhibit during their counseling. It is especially important to identify counseling behaviors which help the woman with a problem pregnancy to reach a quality decision regarding the outcome of her pregnancy. There is much written on how to counsel women with problem pregnancies but little written on what actually is done. The Zotti Abortion Counselor Behavior Tool allowed

abortion counselors to report their behaviors. From the answers of the sample it was possible to portray the usual counseling session between Texas abortion counselors and their clients.

CHAPTER 4

ANALYSIS OF DATA

This descriptive study was conducted by mail to determine whether abortion counselors adhere to their role functions while aiding women with problem pregnancies in the decision making process. Data were collected during a four month period. The sample was characterized using descriptive statistics. Parametric and nonparametric tests of significance were used to analyze research questions. Data related to the third research question were described using frequencies and percentages. Information pertaining to the number of counseling sessions, time interval between pregnancy diagnosis and counseling, method of counseling, and time interval between counseling and the abortion were reported in the section entitled "Other Findings."

Description of Sample

Five questionnaires were mailed to each of 54 abortion clinics located throughout Texas. Clinics were primarily located in the large urban areas as evidenced by Yellow Pages advertisements for abortion facilities in 1980-1982. The number of clinics offering this service increased greatly from 1980 to 1982. In the first mailing,

questionnaires were returned from only 18 (33.3%) abortion clinics, so remailing was done. The final response rate was 26 (48%) of the 54 abortion clinics. Data were gathered during the two months preceding the 1983 Supreme Court Decision and one abortion counselor indicated to this author that many counselors were fearful to respond to the questionnaires in the event that results would be used to make the abortion clinics appear in an ill light. The number of completed questionnaires totaled 56 (21% of the questionnaires mailed). The following narrative describes the 56 abortion counselors surveyed.

The ages of the subjects ranged from 20 to 55 years with a mean age of 31 years and a standard deviation of 7.78 years. The distribution of ages in increments of five year intervals is described using frequencies and percentages in Table 1.

The sample consisted of 52 (93%) women. Additionally, over half of the subjects were married. Table 2 shows the marital status of the participants in the study in frequency and percentages.

One counselor (2% of the sample) replied that she was pregnant at the time of the survey and 27 (48%) of the sample reported having children. At the time of the survey 35 (63%) people in the sample were using birth control.

Table 1

Age Distribution of Subjects by Frequency and Percentage

Age in Years	Frequency	Percent
20-24	10	18.0
25-29	20	36.0
30-34	11	20.0
35-39	7	12.0
40-44	4	7.0
45-49	2	3.5
50-54	0	0.0
55 and older	2	3.5
Total	56	100.0

Table 2

Marital Status of Subjects by Frequency and Percentage

Marital Status	Frequency	Percent
Single	15	27.0
Married	30	54.0
Separated	1	2.0
Divorced	7	12.0
Widowed	2	3.0
Unreported	1	2.0
Total	56	100.0

The amount of experience in counseling varied from 1 month to 22 years. The median was 3 years. Table 3 shows the subjects' length of time counseling by frequency and percentages.

Table 3

Subjects' Years of Counseling by Frequency and Percentage

Years Counseling	Frequency	Percent
0-4	34	61.0
5-9	14	25.0
10 and over	7	12.0
Unreported	1	2.0
Total	56	100.0

Of the 53 counselors who reported their educational preparation, 9 (16%) stated that high school graduation was the highest level of education attained. Twenty-nine (52%) reported having attained a baccalaureate in some field, while 15 (27%) had attained graduate degrees. The three most commonly reported college majors were baccalaureates in social work or psychology and a master's in social work. Only two of the respondents (3.5%) reported majoring in nursing. Thirty (54%) of the respondents stated that they had received training courses to prepare them for abortion

counseling. Table 4 shows the different types of training courses by frequency and percentage.

Table 4

Types of Training Courses by Frequency and Percentage

Types of Training Courses	Frequency	Percent
Planned Parenthood	2	3.5
Texas Problem Pregnancy	3	5.0
College Course	6	11.0
Workshops	2	3.5
National Abortion Federation	3	5.0
On the Job Training	3	5.0
Clinic	7	13.0
Women's Crisis Center	1	2.0
Unreported	29	52.0
Total	56	100.0

The last question on the demographic data sheet asked whether the abortion counselor had had an abortion. Over one-third (20, 36%) of all the respondents reported having had an abortion themselves.

The sample was mostly female with approximately three-fourths (41, 74%) of them age 34 and below. A little over half the sample (30, 54%) were married and 27 (48%) had children. More than one-third (20, 36%) of the group had had abortions themselves. Almost two-thirds (34, 61%) of the group had been counseling four years or less.

Fifty-two percent (29) of the group reported their highest education as a baccalaureate degree, while 27% (15) reported having graduate degrees. Only 11% (6) reported having had formal college courses to prepare them for this counseling. Most others had attended training courses.

Findings

In order to determine whether abortion counselors performed their role functions, three research questions were posed. Nonparametric statistical tests were applied to the data.

Research Question One

The first research question asked: Do abortion counselors adhere to recommended steps to aid women with problem pregnancies in decision making? This question was answered by examining sections one (Assessment) and two (Planning Intervention) of the Zotti Abortion Counselor Behavior Tool. In the assessment section (I) there was a possible score of 65. Scores varied from 13.00 to 60.00. The mean was 42.41 with a standard deviation of 10.31. The following questions had means of less than 3.000 which indicated that the abortion counselors seldom performed these behaviors during the assessment phase.

3. I question the client regarding her usual steps in making difficult decisions. (Mean = 2.786)
7. I question the client regarding whether she is suicidal. (Mean = 1.821)
13. I encourage a married client to tell her husband about the pregnancy if she has not already done that. (Mean = 2.321)

In the planning intervention section (II) there was a possible score of 65. Scores varied from 20.00 to 64.00. The mean was 50.46 with a standard deviation of 8.95. Two questions had means less than 3.000 which indicated that abortion counselors seldom performed these behaviors in the planning intervention phase.

3. I ask the client to describe to me how she imagines an abortion is performed. (Mean = 2.946)
12. I encourage the client to write a balance sheet showing "pro" and "con" for each option. (Mean = 2.714)

Adherence to recommended counseling steps was measured by using the 95% confidence interval. This test demonstrated that abortion counselors in this study did adhere to recommended steps to aid women with problem pregnancies in decision making. Table 5 shows the mean and the 95% confidence interval for each of the two sections.

Table 5

Means and 95% Confidence Intervals for Questionnaire Sections One and Two

Sections	Mean	95% Confidence Interval
Assessment (I)	42.41	39.71 to 45.11
Planning Intervention (II)	50.46	47.66 to 52.34

Research Question Two

The second research question asked: In which of the first two phases of counseling do abortion counselors score higher: assessment phase or planning intervention phase? This was tested using the Wilcoxon matched-pairs test for related measures. This test revealed the mean rank for the assessment phase (section I) was 11.21 and for the planning intervention phase (section II) it was 30.97 ($p \leq .001$). The mean ranks were significantly different. Thus, abortion counselors in this study scored significantly better in the planning intervention phase.

Research Question Three

The third research question asked: How often do counselors perform follow-up counseling after the abortion? Two questions in Section III (General Criteria and Follow-Up) addressed two different aspects of follow-up. Question two asked whether the client usually returned for follow-up

discussion regarding her coping. For this purpose, 30 (53.6%) abortion counselors stated that the client usually did return. Table 6 demonstrates frequency and percentage of clients returning for discussion regarding their coping.

Table 6

Follow-Up Regarding Coping by Frequency and Percentage

Follow-Up	Frequency	Percent
Client Returns	30	53.6
Client Does Not Return	23	41.0
Unreported	3	5.4
Total	56	100.0

Question three asked whether the client usually returned for a follow-up interval to ensure proper contraception use. In this case, 40 (71.4%) subjects stated that clients usually return for this session. Table 7 shows frequency and percentage of clients returning for follow-up related to contraceptive use.

Other Findings

The descriptive data obtained in the last section of the questionnaire (General Criteria and Follow-Up) were related to other findings. Question one in Section III

Table 7

Follow-Up Related to Contraception by Frequency and Percentage

Follow-Up	Frequency	Percent
Client Returns	40	71.4
Client Does Not Return	12	21.4
Unreported	4	7.2
Total	56	100.0

asked how many counseling sessions are usually used to interview each client. In this study, 49 (87.5%) of the abortion counselors reported that they commonly interview the client in one session. Table 8 shows the number of counseling sessions by frequency and percentage.

Table 8

Number of Counseling Sessions by Frequency and Percentage

Number of Sessions	Frequency	Percent
One Session	49	87.5
Two or More Sessions	4	7.1
Unreported	3	5.4
Total	56	100.0

Whether diagnosis of the pregnancy is usually made on the same day as counseling was asked by question four. Of the sample, 25 (44.5%) abortion counselors stated that diagnosis and counseling were done on the same day. Table 9 demonstrates the time interval between diagnosis of pregnancy and counseling by frequency and percentage.

Table 9

Time Interval Between Diagnosis of Pregnancy and Counseling by Frequency and Percentage

Time Interval	Frequency	Percent
Same Day	25	44.5
1-5 Days	15	27.0
6-14 Days	4	7.0
Nonspecific	10	18.0
Unreported	2	3.5
Total	56	100.0

Question five in Section III sought to determine the type of counseling usually used by the abortion counselor. Thirty-seven abortion counselors (66%) reported using individual counseling. Table 10 shows which type of counseling was usually employed by frequency distribution and percentage.

How much time elapsed between counseling and the abortion was the topic of question six in Section III of the

Table 10

Frequency Distribution and Percentage of Types of Abortion Counseling

Type of Counseling	Frequency	Percent
Individual	37	66.0
Group	15	27.0
Both	3	5.0
Unreported	1	2.0
Total	56	100.0

questionnaire. Thirty-eight (68%) of the abortion counselors in this sample reported that counseling and the abortion occur on the same day. Table 11 shows the time interval between counseling and the abortion by frequency and percentage.

Table 11

Time Interval Between Counseling and Abortion by Frequency and Percentage

Time Interval	Frequency	Percent
Same Day	38	68.0
1-7 Days	13	23.0
8-14 Days	1	2.0
Nonspecific	2	3.5
Unreported	2	3.5
Total	56	100.0

Summary of Findings

A description of the 56 abortion counselors in this sample and findings of the study were presented in Chapter 4. Three research questions were examined and the appropriate statistical tests were applied. According to the 95% confidence interval, abortion counselors in this study did adhere to role functions during both the assessment and planning intervention phases of counseling. The Wilcoxon matched-pairs test indicated that abortion counselors scored significantly higher in the planning intervention phase than in the assessment phase. Descriptive findings revealed that counselors performed follow-up more often for the purpose of contraception than for coping problems. Other findings included that the client is most often counseled individually in one session on the same day as the abortion. The diagnosis of the pregnancy may or may not occur on the same day as the counseling.

CHAPTER 5

SUMMARY OF THE STUDY

A skilled abortion counselor can aid the client with a problem pregnancy in the decision making process by helping her to mobilize her inner resources, refine her problem solving techniques, and learn skills in high quality decision making. With this tenet in mind, three research questions were proposed and investigated via a descriptive survey. Chapter 5 includes the summary, discussion of findings, conclusions and implications, and recommendations for further study.

Summary

A descriptive study was conducted by mail to determine whether abortion counselors adhere to role functions while counseling clients with problem pregnancies. Three research questions were proposed and investigated using an instrument designed by the author. The nonprobability sample consisted of 56 abortion counselors in clinics in Texas.

The sample was predominantly female with approximately three-fourths of them age 34 and below. More than half were married and 48% reported having children. Thirty-six percent of the group had had abortions themselves. Sixty-one

percent had been counseling four years or less. Over half of the group reported a baccalaureate degree as their highest education and an additional 27% stated that they had graduate degrees. Only about one-tenth reported having had formal college courses to prepare them for this counseling. Most others had attended training courses.

According to the 95% confidence interval, abortion counselors in this study did adhere to role functions during the assessment and intervention phases of counseling. The Wilcoxon matched-pairs test indicated that abortion counselors scored higher in the planning intervention phase than in the assessment phase. Descriptive findings revealed that counselors performed follow-up more often for the purpose of contraception than for coping problems. Other findings included that the client is most often counseled individually in one session on the same day as the abortion. The diagnosis of the pregnancy may or may not occur on the same day as the counseling.

Discussion of Findings

Some of the characteristics of abortion counselors as described by Dauber (1974) have changed. Counselors in this sample were somewhat older. Whereas Dauber had reported that 75% of the counselors she surveyed were between 21 and 31, in this sample the median age was 29 years. The fact

that this group is older probably coincides with the finding that the present sample reported 52% had no children, while Dauber's group reported that 65% had no children. Use of birth control also decreased. Eighty-five percent of Dauber's sample were using birth control as opposed to 63% of the current sample using birth control. Years engaged in abortion counseling has increased--probably partly because of abortion counseling being a fairly new field at the time of Dauber's research. She reported that 75% of her sample had counseled less than two and one-half years, while 75% of the sample from the present study had counseled over five years.

There was also a change in the percentage of nurses engaged in abortion counseling. In Dauber's (1974) sample, 36% were nurses, whereas in this study only 3.6% were nurses performing in the role of abortion counselor. An area which has not changed much is the percentage of abortion counselors reporting training for their role. Forty-seven percent of Dauber's group reported training although none reported any formal academic training. In the present study 54% reported training for their role and of this only 11% reported formal academic training. Another change in the sample was the ratio of abortion counselors who themselves had received abortions. Dauber reported one in five

(20%) and in this present study over one in three (36%) reported having had an abortion. This growth may be due to the increase in numbers of abortions in the general population that have been steadily occurring (Henshaw, Forrest, Sullivan, & Tietze, 1981).

Morley, Messick, and Aguilera (1967) stated that a correct assessment of the problem is extremely important in choosing an effective intervention. However, in this study it was found that abortion counselors scored significantly higher in the planning intervention phase. Therefore, in the future, abortion counselors might concentrate on improving assessment skills.

Several authors (Baudry & Wiener, 1974; Bracken, 1977; Dunlop, 1978; Scott, 1972) recommended steps to be taken in abortion counseling which were combined into the first two sections of the Zotti Abortion Counselor Behavior Tool. Additionally, techniques of crisis intervention from Aguilera and Messick (1982) were included in the questionnaire. Statistical tests revealed that abortion counselors do adhere to role functions in counseling in both assessment and planning intervention phases. However, some items on the questionnaire were not done on a usual basis. They will be discussed as follows.

In the assessment phase Aguilera and Messick (1982) recommended that the counselor inquire regarding the client's usual steps in making decisions. The client's answers give clues regarding usual coping methods which may affect her present behavior. The mean score for this item in the present study was 2.786 which indicated that counselors often did not assess the client's usual coping methods. Aguilera and Messick also recommended during the assessment phase that the counselor very directly and specifically ask the client whether she may be contemplating suicide. The mean score for this item was 1.821 which indicated that abortion counselors in the present study seldom asked if the client is suicidal. The reasons for this failure are only conjecture on the part of this author. It may be that abortion counselors did not incorporate crisis theory in their counseling; hence, they do not think to ask this question. Another reason may be the fact that the woman comes to the abortion clinic which indicates that she feels she has options in her life.

Although the husband's permission is not needed in order for a woman to have an abortion, Dunlop (1978) recommended that he should be informed of the pregnancy in nearly all cases. Item 13 in the assessment phase of this study's questionnaire asked whether abortion counselors encouraged

the client to tell her husband about the pregnancy. Experts who reviewed this questionnaire to determine content validity concurred with the inclusion of this item. However, abortion counselors in this sample often did not encourage the woman to share the information that she was pregnant with her husband as evidenced by the mean score for this item (2.321). It would appear that abortion counselors in the United States may disagree with Dunlop, a British psychiatrist, and that in America there are conflicting ideas regarding how much information a wife should share with her husband.

Baudry and Wiener (1974) recommended asking the client to describe how she imagines an abortion is performed in order to detect fears or misconceptions regarding the procedure or the effects of the procedure. The detection of fear is important since Fielding, Sachtleben, Friedman, and Friedman (1978) found in their study that fear was the single most influential factor in delaying a decision regarding the outcome of the pregnancy. The item relating to this was included in the planning intervention section of the questionnaire. This question was not often asked by abortion counselors in this sample as can be seen by the mean of this item (2.946).

Bracken (1977) recommended the use of a balance sheet showing "pro" and "con" for each option facing a woman with a problem pregnancy. The purpose of the sheet is to consider the client's decisional process and assure that all aspects are considered fully. This approach apparently was not often used by abortion counselors in this sample as can be seen by the item mean of 2.714. However, neglecting to use the balance sheet does not mean that abortion counselors did not encourage full evaluation of positive and negative aspects in the decision; it only means that this approach often was not used.

Admire and Byers (1981) described typical stages in the decision making process of an adolescent with a problem pregnancy. The first stage is denial in which the client is unable to absorb information or to make decisions. The other stages are exploration phase in which she examines alternatives, working-through phase in which she had made a decision but needs to talk about available resources, and resolution phase in which she actually makes plans involving the resources. Scott (1972) identified five phases for the client with a problem pregnancy. The first two stages were the same: denial and exploration phases. Scott then described a third stage in which the client had made a decision but integration was not possible because of denial

or distortion. His last two steps were similar to the working-through phase and resolution phase listed by Admire and Byers (1981). Whether the client is allowed time to progress through the stages in the decision making process is related to two questions in Section III, General Criteria and Follow-Up, of the Zotti Abortion Counselor Behavior Tool. Question 4 asks whether diagnosis of the pregnancy is usually made on the same day as counseling. Almost half (44.5%) of the sample in this study stated that diagnosis and counseling were done on the same day. The other question which relates to whether the client has time to pass through phases in decision making before the actual decision and intervention is question 6 in Section III. This question asks how much time elapses between counseling and the abortion itself. In this sample, 68% reported the abortion occurs on the same day as the client receives counseling.

Baudry and Weiner (1974) suggested that the physician allow one to two sessions for discussion with the client who has a problem pregnancy. Scott (1972) advocated two sessions with the client with a problem pregnancy to avoid a hasty decision which might lead to regret. The American Academy of Pediatrics (1979) also recommended a second visit to review a tentative decision made by the client between

visits. Abortion counselors in this study reported that 87.5% usually interviewed the client in only one session.

Bracken (1973) studied which type of counseling was preferred by women undergoing counseling and found that while all women preferred individual counseling, younger women responded to the abortion in a more positive manner following group counseling. Smith (1982) also stated that while individual counseling is desirable, group counseling is most effective with teenagers undergoing abortion counseling. Question 5 in Section III asked which type of counseling was usually used by the abortion counselor. In the present study, 66% of the abortion counselors used individual counseling, 27% used group counseling, and 5% used both. One (2%) counselor did not respond to this question. There was no attempt in this study to relate type of counseling with the age of the client.

Conclusions and Implications

Based on the study findings, several conclusions were drawn. First, a decade has brought changes in the typical abortion counselor: She is older, has been counseling longer, and is more likely to have had an abortion herself.

Training for the role functions of an abortion counselor has changed little in a decade. There is still

little formal academic preparation for this role and training is done by several organizations with apparently no standard criteria.

Abortion counselors did adhere to role functions in aiding women with problem pregnancies during decision making. However, it appeared that they probably did little teaching regarding high quality decisional skills.

Although abortion counselors did adhere to role functions, it was questionable whether the time intervals between diagnosis, counseling, and the abortion allowed the client time to pass through all phases of the decisional process and to the resolution phase.

Implications for nurses included the following. Nurses in Texas at the time of this study were seldom involved in abortion counseling. Nurses can expect that in most instances abortion counselors have taken appropriate steps to help the client through decision making.

The Zotti Abortion Counselor Behavior Tool can be used by nurses to identify counseling behaviors to be utilized during the decision making process for the abortion client. This can help nurses to identify behaviors which may need to be reinforced or augmented when treating a client undergoing an abortion.

Recommendations for Further Study

Some recommendations for future study would serve to strengthen efforts in this area of investigation. Specific recommendations are:

1. A larger, randomly selected sample of abortion counselors in several states should be used to strengthen the representation of the results and increase generalizability.
2. Section III of the Zotti Abortion Counselor Behavior Tool should be revised in order to determine a usual time interval between diagnosis of pregnancy, counseling, and the abortion.
3. Section III of the Zotti Abortion Counselor Behavior Tool should be revised to include a question regarding the usual amount of time spent counseling each abortion client.

APPENDIX A

LETTER TO SUBJECTS

Dear Counselor/Clinic Director:

I am a graduate nursing student at Texas Woman's University. I am surveying abortion counselors regarding their counseling behaviors. I would be grateful for your input and help in this endeavor.

Enclosed in this package are five questionnaires which I would appreciate your distributing to your abortion counselors using these instructions to protect the counselor's rights and assure anonymity:

1. State that participation in the study is voluntary.

2. Please do not write names on the questionnaire.

3. Please direct the counselor's attention to the statement that the completion and return of the questionnaire will indicate consent for participation in this study.

In addition to the above, the return envelope will be coded in order for me to record whether or not you are interested in a copy of the results of this study, and then the return envelope will be destroyed. After data analysis, all questionnaires will be destroyed and all results will be reported in group format only.

Please return the completed questionnaires in the return envelope as soon as possible. Thank you for your help.

Sincerely,

Mrs. Marianne Zotti, RN, BSN
6326 King Post
Houston, TX 77088
(713) 937-7802

APPENDIX B

QUESTIONNAIRE PACKET

Dear Abortion Counselor:

I am a graduate student in Community Health Nursing at Texas Woman's University. I am intending to survey abortion counselors regarding their counseling behaviors and have devised a questionnaire in order to do this. I need now to have it evaluated.

I have been given your name as an expert in the field of abortion counseling so I hope that you will answer the questions with the appropriate answer and then fill in the evaluation sheet on the back. Thank you very much for your help.

Sincerely,

Mrs. Marianne Zotti, RN
6326 King Post
Houston, TX 77088
(713) 937-7802

MZ/rb

Enc.

I UNDERSTAND THAT MY RETURN OF THE COMPLETED QUESTIONNAIRE INDICATES MY CONSENT TO PARTICIPATE IN THE STUDY.

ZOTTI ABORTION COUNSELOR BEHAVIOR TOOL

Instructions: This questionnaire is designed to describe behaviors in the practice of abortion counseling. Please circle the one answer which best describes how often you do the behavior listed while counseling a woman with a problem pregnancy.

Key: A = Always S = Seldom
U = Usually N = Never
F = Frequently N/A = Not Applicable

I. Assessment

A. I question the client regarding:

1. the length of time between her first suspicion that she was pregnant and confirmation of the fact. A U F S N N/A
2. with whom she first described the probability of being pregnant. A U F S N N/A
3. the time interval between her first suspicion of pregnancy and her first discussion about it with someone. A U F S N N/A
4. who first suggested an abortion. A U F S N N/A
5. the type of contraception she has been using. A U F S N N/A
6. the circumstances surrounding the time period in which she conceived. A U F S N N/A
7. any personal loss around the time of conception. A U F S N N/A
8. her usual steps in making difficult decisions. A U F S N N/A
9. how the pregnancy has affected her relationship with her sexual partner. A U F S N N/A
10. who influences her most. A U F S N N/A
11. which important people in her life are informed of the situation. A U F S N N/A
12. how the important people in her life view her pregnancy. A U F S N N/A
13. whether she is suicidal. A U F S N N/A
14. previous psychiatric conditions. A U F S N N/A
15. whether she feels she has a choice in her situation. A U F S N N/A

B. I ask the client to describe to me:

16. her positive feelings towards her pregnancy. A U F S N N/A
17. her negative feelings towards her pregnancy. A U F S N N/A
18. the menstrual cycle and the time period of fertility. A U F S N N/A

19. the effectiveness of differing types of contraception.	A	U	F	S	N	N/A
20. her relationship with her sexual partner.	A	U	F	S	N	N/A
21. the state of her relationship with her parents if she is young or unmarried.	A	U	F	S	N	N/A

C. I encourage:

22. another session of counseling for a client complaining of irritability and sleepless nights.	A	U	F	S	N	N/A
23. a quick abortion for a client complaining of many vague disorders unrelated to the pregnancy.	A	U	F	S	N	N/A
24. more counseling for a client with increasing moodiness and depression.	A	U	F	S	N	N/A
25. a married client to tell her husband about the pregnancy if she has not already done that.	A	U	F	S	N	N/A
26. a quick abortion for the client who does not want her husband to know about the pregnancy.	A	U	F	S	N	N/A
27. a pregnant teenager whose mother favors abortion to have an abortion quickly.	A	U	F	S	N	N/A
28. an abortion recommended by a physician for physical reasons to be done as soon as possible.	A	U	F	S	N	N/A
29. further counseling for a woman who states that it is her husband's/boyfriend's wish for her to abort.	A	U	F	S	N	N/A
30. a woman to tell her husband about her pregnancy even when he wants no more children.	A	U	F	S	N	N/A

II. Planning Interventions

A. I ask the client to describe to me:

1. how she imagines her life would be if she carried the pregnancy to term.	A	U	F	S	N	N/A
2. realistic possibilities for support and care if she carried this pregnancy to term.	A	U	F	S	N	N/A
3. how she imagines her life would be if she went through the adoption procedure.	A	U	F	S	N	N/A
4. how she imagines an abortion is performed.	A	U	F	S	N	N/A
5. any fears she has regarding an abortion.	A	U	F	S	N	N/A
6. what type contraceptive she will use in the future.	A	U	F	S	N	N/A
7. detailed plans she has made for the abortion.	A	U	F	S	N	N/A

Key: A = Always S = Seldom
U = Usually N = Never
F - Frequently N/A = Not Applicable

8. realistic contingency plans in the event of a complication following the abortion. A U F S N N/A

9. whether or not her decision was made on the advice of authority figures in her life. A U F S N N/A

10. how each option regarding this pregnancy could be carried out in her life. A U F S N N/A

B. I describe to the client:

11. the adoption procedure. A U F S N N/A

12. factual information on each option. A U F S N N/A

13. different methods of contraception. A U F S N N/A

14. the discomfort she can expect during the abortion. A U F S N N/A

C. I encourage:

15. the client to make her own decision. A U F S N N/A

16. more counseling for the client who has made a definite decision yet complains of vague symptoms. A U F S N N/A

17. the client to write a balance sheeting showing "pro" and "con" for each option. A U F S N N/A

D. I refer to the proper agency:

18. the client who elects to carry the pregnancy to term. A U F S N N/A

19. the client who prefers the adoption option. A U F S N N/A

Instructions: In Part III the first five questions follow the format of above. In the last three questions, please circle the one answer which is best according to what is usually done in your clinic. Also, please fill the correct number in the blank if you choose that answer.

III. General Criteria and Follow-Up

1. I usually interview the client:

   a) in one session.

   b) in two or more sessions.

2. The client usually:

   a) returns following the abortion for follow-up discussion regarding her coping.

   b) does not return after the abortion.

3. The client usually:

   a) returns for a follow-up interval to ensure proper contraception use.

   b) does not return for follow-up regarding contraception use.

4. Diagnosis of the pregnancy usually is made:

   a) on the same day as counseling.

   b) _____ days prior to counseling.

5. Counseling of women usually is done:

   a) on an individual basis.

   b) in a group setting.

6. Counseling usually is performed:

   a) on the same day as the abortion.

   b) _____ days prior to the abortion.

DEMOGRAPHIC DATA

1. Your age is: _____

2. Your sex is:

   a. Male

   b. Female

3. Your marital status is:

   a. Single

   b. Married

   c. Separated

   d. Divorced

   e. Widowed

4. Are you currently pregnant?

   a. Yes

   b. No

5. Do you have any children?

   a. Yes

   b. No

6. Are you currently using some method of birth control?

   a. Yes

   b. No

7. How long have you been doing counseling? _____

8. Circle highest education received:

   a. High School Graduate

   b. College Graduate Major field _____

   c. Graduate Degree Major field _____

   d. Other--please explain

9. Have you received any training courses for counseling people with problem pregnancies?

   a. Yes

   b. No

   If yes, please list training and organization providing it.

   _____

   _____

10. Have you ever had an induced abortion yourself?

    a. Yes

    b. No

EVALUATION SHEET

1. Each item is clear.

   a. yes

   b. no -- If no, please list item numbers that are not clear.

2. Each item measures usual behaviors in the practice of abortion counseling.

   a. yes

   b. no -- If no, please list item numbers that do not measure usual behaviors.

3. Items in Part I measure assessment behaviors.

   a. yes

   b. no -- If no, please list item numbers which do not measure assessment behaviors.

4. Items in Part II measure behaviors in planning interventions.

   a. yes

   b. no -- If no, please list items numbers which do not measure behaviors in planning intervention.

5. Items in Part III measure general criteria and follow-up.

   a. yes

   b. no -- If no, please list item numbers which do not measure general criteria or follow-up.

6. Please feel free to express general comments.

APPENDIX C

ZOTTI ABORTION COUNSELOR BEHAVIOR TOOL--

FINAL FORM

I UNDERSTAND THAT MY RETURN OF THE COMPLETED QUESTIONNAIRE INDICATES MY CONSENT TO PARTICIPATE IN THE STUDY.

ZOTTI ABORTION COUNSELOR BEHAVIOR TOOL

Instructions: This questionnaire is designed to describe behaviors in the practice of abortion counseling. Please circle the one answer which best describes how often you do the behavior listed while counseling a woman with a problem pregnancy.

Key: A = Always S = Seldom
U = Usually N = Never
O = Occasionally

I. Assessment

A. I question the client regarding:

1. the time interval between her first suspicion of pregnancy and her first discussion about it with someone.	A	U	O	S	N
2. who first suggested an abortion.	A	U	O	S	N
3. her usual steps in making difficult decisions.	A	U	O	S	N
4. how the pregnancy has affected her relationship with her sexual partner.	A	U	O	S	N
5. who influences her decisions most.	A	U	O	S	N
6. how the important people in her life view her pregnancy.	A	U	O	S	N
7. whether she is suicidal.	A	U	O	S	N
8. whether she feels she has a choice in her situation.	A	U	O	S	N

B. I ask the client to describe to me:

9. her positive feelings towards her pregnancy.	A	U	O	S	N
10. her negative feelings towards her pregnancy.	A	U	O	S	N
11. her menstrual cycle and the time period of fertility.	A	U	O	S	N

C. I encourage:

12. another session of counseling for a client complaining of irritability and sleepless nights.	A	U	O	S	N
13. a married client to tell her husband about the pregnancy if she has not already done that.	A	U	O	S	N

II. Planning Interventions

A. I ask the client to describe to me:

1. realistic possibilities for support and care if she carries this pregnancy to term.	A	U	O	S	N
2. how she imagines her life would be if she went through the adoption procedure.	A	U	O	S	N
3. how she imagines an abortion is performed.	A	U	O	S	N
4. any fears she has regarding an abortion.	A	U	O	S	N
5. detailed plans she has made for the abortion.	A	U	O	S	N

6. realistic contingency plans in the event of a complication following the abortion.	A	U	O	S	N
7. whether or not her decision was made on the advice of authority figures in her life.	A	U	O	S	N
B. I describe to the client:					
8. different methods of contraception.	A	U	O	S	N
9. the adoption procedure.	A	U	O	S	N
10. the discomfort she can expect during the abortion.	A	U	O	S	N
C. I encourage:					
11. the client to make her own decision	A	U	O	S	N
12. the client to write a balance sheet showing "pro" and "con" for each option.	A	U	O	S	N
13. I refer the client who prefers the adoption option to the proper agency.	A	U	O	S	N

Instructions: In Part III the first five questions follow the format of above. In the last three questions, please circle the one answer which is best according to what is usually done in your clinic. Also, please fill the correct number in the blank if you choose that answer.

III. General Criteria and Follow-Up

1. I usually interview the client:

   a) in one session.

   b) in two or more sessions.

2. The client usually:

   a) returns following the abortion for follow-up discussion regarding her coping.

   b) does not return after the abortion.

3. The client usually:

   a) returns for a follow-up interval to ensure proper contraception use.

   b) does not return for follow-up regarding contraception use.

4. Diagnosis of the pregnancy usually is made:

   a) on the same day as counseling.

   b) _____ days prior to counseling.

5. Counseling of women usually is done:

   a) on an individual basis.

   b) in a group setting.

6. Counseling usually is performed:

   a) on the same day as the abortion.

   b) _____ days prior to the abortion.

DEMOGRAPHIC DATA

1. Your age is: _____

2. Your sex is:

   a. Male

   b. Female

3. Your marital status is:

   a. Single

   b. Married

   c. Separated

   d. Divorced

   e. Widowed

4. Are you currently pregnant?

   a. Yes

   b. No

5. Do you have any children?

   a. Yes

   b. No

6. Are you currently using some method of birth control?

   a. Yes

   b. No

7. How long have you been doing counseling? _____

8. Circle highest education received:

   a. High School Graduate

   b. College Graduate Major field _____

   c. Graduate Degree Major field _____

   d. Other--please explain

9. Have you received any training courses for counseling people with problem pregnancies?

   a. Yes

   b. No

   If yes, please list training and organization providing it.

   _____

   _____

10. Have you ever had an induced abortion yourself?

    a. Yes

    b. No

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