PREABORTION ANXIETY IN WOMEN AND ITS RELATIONSHIP TO THE MALE PARTNER'S INVOLVEMENT AND THE WOMAN'S ABORTION ATTITUDE

A THESIS

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CHAPTER I

INTRODUCTION TO LITERATURE

The literature on abortion has focused on subjective feelings of abortion patients, possible aftereffects, medical risks, surgical safety, public opinion, and effective contraception. Surprisingly, there is little information on the patient's attitude toward abortion and the contribution of her environmental support system, specifically the male partner involved, and the result of these elements on the patient's anxiety. These aspects are relatively unexplored and are only recently being mentioned in abortion literature. The focus of the present study is three-fold: (1) to determine whether the presence or absence of the male partner of a woman seeking abortion appears to be related to the patient's level of anxiety at the time of the abortion, (2) to explore the couple's relationship as the woman perceives it and the consequence of the relationship on the woman's anxiety, and (3) to investigate the woman's attitude toward abortion and how the attitude contributes to anxiety if it is in fact related. In addition, an attempt will be made to determine whether age and religion are related to the woman's abortion attitude.

Anxiety in abortion patients

When examining the decision-making process involved in and the psychological reaction to abortion, the most noted characteristic of abortion patients is anxiety. Women seeking an elective abortion procedure often appear to experience anxiety before and during the operation. During the past decade, there have been numerous studies and reviews concerned with the emotional reactions of therapeutic abortion applicants (Burkle, 1977; Shainess, 1968; Wallerstein, Kurtz, & Bar-Din, 1972; Walter, 1970; Williams, Jones, Workhoven, & Williams, 1975). The findings are contradictory. From individual self-reports, postabortion feelings ranged on a continuum from regret, incapacity to work, impaired mental health, and crying to indifference, condition unchanged, and mild reproach. Finally, most individuals experienced relief, satisfaction, and much smiling.

Anxiety may be manifested and expressed by different individuals in different ways depending upon the individual's psychological, physiological, and emotional background. All surgical procedures produce anxiety in most patients because there are unknown factors about possible discomforts and outcomes (Graham & Conley, 1971). Anxiety may be defined as the "apprehensive tension or uneasiness which stems from the subjective anticipation of imminent or impending danger, in which the source is largely unknown or

unrecognized" (Graham & Conley, 1971, p. 114). It is often conveyed through the patient as an alarm reaction.

Freemen (1978) reported that nearly all of 329 women seeking abortion in June-July 1975 in Philadelphia were distressed to some degree. Ambivalence is a predominant feeling in abortion seekers. In Freeman's study, 28% said that they had expected to have abortions if unwanted pregnancies occurred, 37% said they were certain they never would, and 13% said they had not known what they would do. For many, the abortion decision contradicted their perceptions about themselves. Differences in emotional acceptance of abortion experience were significantly associated with personality characteristics. Those women who had not resolved their abortion experience four months later reported having attributes that suggested a negative self-image or avoidance of feelings. Those women who had resolved their feelings indicated a positive self-image, greater sense of mastery and achievement, as well as willingness to express and cope with feelings.

Walter (1970) found that the reaction to abortion is not entirely situational; rather it is almost entirely determined by a woman's previous psychological set. The previously held common view has been that abortion frequently precipitates severe negative reactions. Presently there is a shift away from that viewpoint. Recent studies

reveal that extreme reactions are rare and, when they do occur, are generally associated with problems existing prior to the abortion (Adler, 1975). Negative emotions present two different issues: (1) socially based emotions (i.e., violation of norms) and (2) internally based emotions (i.e., sense of loss, regret, guilt, anger). When looking at the overall abortion response, these socially and internally based negative emotions are experienced by abortion patients to a small extent. Feelings of relief and happiness are dominant. Abortion patients experience these responses fairly strongly during the abortion experience and the strength of these positive emotions is unrelated to the factors which influence the negative emotions. This finding adds evidence to current studies suggesting that the predominant emotional responses to abortion are happiness and relief (Adler, 1975). These findings are inconsistent with earlier studies.

There are many deficiencies in sampling and in research design in abortion studies, including failure to investigate preabortion emotional status of the patient and the presence and extent of a support system involving the male partner. It is likely that anxiety is a function of relevant psychological aspects of the woman including her perceived relationship with the male partner involved, the presence or absence of the male partner at the time of the

abortion, and her attitude toward abortion. These aspects are relatively new to the literature on abortion and the lack of investigation in these areas are indicative of the deficiencies in sampling and research noted above.

Male partner involvement

The men who accompany women to abortion clinics usually have not been offered any of the educational services offered to patients. Those men who do not accompany women to the abortion clinic forfeit their most readily available opportunity to learn about the abortion procedure and possible side effects. It is common practice for many clinics to recommend that patients bring someone with them (Brashear, 1973), and many patients do bring at least one other person. Abortion counselors have noted that significant others, specifically the male partner involved, have been shown to be influential in decision-making surrounding unplanned pregnancies. Rothstein (1977) also found this to be true when sampling 60 men who accompanied their female partners to an abortion clinic. Two foci of the present study are the patient-male partner relationship and the presence or absence of the male partner at the time of the abortion.

As for the male partners, there is little known about this group of people. Newman (1973) pointed out that "there are practically no studies of the background characteristics, psychodynamics, and behavior of the male partners of females

seeking and obtaining abortions" (p. 560).

There is a presumed mutuality of influence within the patient-male partner relationship. The following examples illustrate some of the kinds of interactive effects of this relationship that were found to surround the abortion decision: (1) Bracken, Hachamovitch, and Grossman (1974) found that the delay in reaching the decision to have an abortion correlated with lack of support from significant others; (2) Bracken et al. (1974) found a significantly more favorable reaction to abortion in women who judged their partners to be more supportive; (3) Freeman (1978) found that at the time of a four-month postabortion follow-up, women who had resolved the abortion experience perceived partner support for the abortion decision while every woman who described the abortion experience as upsetting lacked partner support; and (4) a study of 432 girls aged 12-17 who were unintentionally pregnant showed that, of those who decided to abort their pregnancies, 50% said that they had been influenced in the decision by their boyfriends (Digest, 1978).

The decision to abort may be a joint decision by the woman and her male partner; therefore, the impact on the man and the dyadic relationship are relevant. The woman's perception of her relationship with the man may be an important determinant of her ability to cope with the experience and her amount of anxiety.

Some men are emotionally invested in the woman and emotionally involved in the abortion. Many women consider the male partner's response to the abortion experience as significant (Rothstein, 1977). The Rothstein study randomly sampled 60 men who accompanied their female partners to the Bronx Municipal Hospital abortion clinic. These men wanted to accompany their partners and support them and share the responsibility for preventing pregnancy yet they were inadequately informed about birth control and abortion and showed little interest in involvement in the clinical services offered to the patients. The Rothstein study sought to explore the relationships of couples seeking abortion. There is only a small body of research concerning abortion's impact on the couple's relationship. In studying couples who have sought abortion, the majority of the relationships were characterized by intensity, stability, a sense of mutuality, and understanding and trust, but not as much by a sense of shared responsibility. In the Rothstein sample, the relationships seemed fairly solid (long-standing), most felt they communicated their feelings well and understood each other's feelings, and the majority of the relationships were neither casual nor conflict-ridden. In this sense, abortion may have a growth-promoting effect upon some couples. Whether abortion evokes crisis in the relationship or not is still unknown. Crisis refers to a time when individuals are faced with an obstacle

that represents a danger to them. Their usual ways of coping with their problems are not effective enough to reduce the high level of tension they are experiencing. The individual may feel helpless, defeated, and alone (Caplan, 1963). Researchers have not resolved the issue of whether abortion evokes crisis or promotes growth. Therefore, another inconsistency in abortion literature may be noted.

Heineman (1973) studied a limited sample of 40 women seeking abortions at a clinic in New York City. Most of the women were involved in a serious relationship with the reputed fathers. Almost half of the women planned to continue the relationship with the man involved; the others planned on marriage.

Relationship factors

Keeping in mind the Heineman and Rothstein findings, the request for abortion and the abortion itself may be seen as components of an ongoing relational process. An abortion is an occasion when a women may feel entitled to enlist the help of her total relationship system in arriving at a decision. Ignoring the relationship dynamics is ignoring the implications for mutual caring and long-term trust (Cotroneo & Krasner, 1977). To the extent that the couple are involved in an emotionally significant relationship with each other, each partner's mood and emotional state will have a profound effect on the other's. As in any important

social system, input from either partner affects both of them, and negative feelings from either often reverberate through the system, to the detriment of everybody within it (Satir, 1967).

Although many women may fail to recognize the extent to which their support system influences them, counselors in the field of abortion support the opinion that the male partner involved may have a highly significant influence on the woman. The presence of the male partner at the time of abortion may in itself produce feelings of anxiety. Two studies have noted abnormally high anxiety levels in male partners of abortion patients (Gordon, 1978; Lees, 1975). These findings are supported by the subjective observations of abortion providers that the significant others of their patients are usually very anxious. When the problem of an unwanted pregnancy arises, men are typically moved from their customary decision-making, action orientation role (Lees, 1975). They must often sit anxiously on the sidelines while the woman takes over. This may perhaps have the effect of precipitating anxiety for both partners, and may have long-term implications for their relationship. A triangular relationship between patient, male partner, and physician suddenly replaces the dyadic relationship of the couple. The male inevitably carries the least influence and has the least power in the abortion issue. This may

produce stress and helplessness within the male partner which possibly influences and adds to anxiety in the woman.

Through consultations and interviews with counselors and doctors in the field of abortion, it has been noted that many women have requested that their male partners not accompany them to the abortion clinic (Boyd, Note 1). Through subjective observations it appears as though the presence of the male partner adds to any anxiety which already exists in the woman. His presence enhances feelings of discomfort and uneasiness. Many women do not wish for their male partners to participate in the preabortion counseling session. Many abortion patients seem to prefer a one-to-one individual session where the women can focus more closely on their own feelings and anxiety resolution rather than on additional anxiety expressed by the male partner. His presumed lack of knowledge may foster anxiety and promote stronger anxious feelings in the woman.

Although abortion may range from a time of crisis to a time of personal growth, most persons who go through the abortion experience do not maintain the characteristic crisis behaviors of high panic or depression (Shainess, 1968). Caplan (1963) noted that the most significant factors for positive resolution of a stressful condition are the individual's relationship with significant others and their responses to the crisis. It follows, then, that the

presence or absence of a significant male partner and the nature of the relationship are important mediating variables which may serve to lessen or possibly increase the effect of the presumed crisis for both partners. Abortion counselors have increasingly recognized that the male partner plays a significant role in the woman's reaction to the procedure, especially at the time of the abortion itself.

Woman's abortion attitude

Presumably, the more negative the woman's attitude toward abortion, the higher risk that woman runs of experiencing a negative psychologic reaction and escalating anxiety levels. It has been shown that attitudes toward abortion may vary depending on demographic variables such as race, sex, religion, family size, college education, etc.

Through various public opinion surveys, Blake (1971) has noted that the non-Catholic, college-educated men are more favorable toward abortion than non-Catholic, college-educated women. Also, the upper-class males are more supportive for the freedom of abortion than are upper-class women. In addition, the amount of disapproval by Catholics has decreased rapidly since the beginning of the 1960 decade.

Maxwell (1970) sampled 323 undergraduate students in 1968. He found that males were more liberal in their attitudes toward abortion than were females, upperclassmen were

more favorably inclined toward abortion than lowerclassmen, and students actively involved in church activities were more conservative than those students with moderate, little, or no activity in church. In addition, students who were from families having four or more children were most conservative while students from families with two or three children were more liberal. Students who were an only child were the most liberal.

Lastly, it has been found in black populations which have been studied that abortion is seen as the "white man's" way of eliminating the black race (Hamrick, Dollar, Scruggs, & Wardlow, 1977). Some blacks believe that government funding for abortions is a way to prevent minorities from increasing their percentage of the total population. With this information in mind, a confounding variable to the woman's attitude may be the ethnic group to which she belongs (whether it be Afro-American, Mexican-American, Chinese, or any other minority).

As women of childbearing age can be viewed as the potential consumers of abortion, their attitudes play an important role in their response to abortion. Through the years there has been a steady increase in abortion numbers and rates. Data drawn from five U.S. Gallup Polls taken from 1962-1969 and from the National Fertility study of 1965 indicated that abortion was most strongly supported by

the non-Catholic, male, well-educated establishment (Blake, 1971). By 1970, the general public attitude was moving in a liberal direction. Populations across the United States were largely ambivalent. The Far West and East led in support for abortion. The South was the bastion of conservative attitudes and the disapproval among non-Catholics in the South was higher than among Catholics in the country as a whole. The Midwest expressed disapproval of abortion for economic or financial and elective reasons (Blake, 1971).

A sample of 489 women seeking elective abortions at a New York clinic indicated that more favorable reactions to abortion were received from the married and older women (Bracken et al., 1974). In addition, a survey of 353 undergraduate students at a Memphis university revealed the following: (1) the population sample strongly favored abortion availability, (2) the majority of the population were in favor of abortion remaining legal, and (3) most of the students were unsure as to when life begins (Hamrick et al., 1977). Although some of the women in the sample would not choose abortion if they had an unplanned pregnancy, they still advocated the freedom to choose abortion. Accordingly, an additional focus of the present study is the correlation of age and religion with the woman's abortion attitude. Due to the fact that there has been no systematic survey of abortion patients in this area of attitude, the probable

direction of the results is questionable. It is likely that the younger women will have more favorable attitudes toward abortion than the older women. Also, it is likely that non-Catholic women will have more favorable abortion attitudes than Catholic women.

The purpose of this study is to determine whether there are significant correlations between the woman's level of anxiety and (1) the woman's perception of her relationship with the man involved, (2) the presence or absence of the male partner at the time of the abortion, and (3) the woman's attitude toward abortion. In addition, the study will determine whether there are correlations between the woman's abortion attitude and (1) her age and (2) her religion. It is hypothesized that (1) higher anxiety levels will be found in those women who perceive their relationship as being more positive, reflecting closeness and support, as compared to women who do not perceive their relationship so positively, (2) higher anxiety levels will be found in those women whose male partners have accompanied them to the clinic due to reverberating anxious feelings throughout the system, (3) women with more negative or conservative attitudes toward abortion will have higher anxiety levels than women with positive or liberal attitudes, and (4) non-Catholic and younger women will have more favorable attitudes toward abortion than will older women and Catholic women.

CHAPTER II

METHOD

Subjects

Subjects consisted of 100 women seeking first trimester abortions at a private abortion clinic in a large southwestern city. There were two groups of patients: those women whose male partners were present at the time of abortion (50 patients) and those women whose male partners were not present (50 patients). Patients were tested every day for 3½ weeks under the assumption that this time period of year was no different from any other time period of year. Once each group had reached its quota, data collection for that group was discontinued. Participation in the study was on a voluntary basis and the treatment of the patients was in accordance with the ethical standards of the APA. All patients participating in the study gave written informed consent (see Appendix A). All 100 abortions were performed by a licensed physician between March and April, 1980.

Instruments

The standardized A-State scale of the Spielberger State-Trait Anxiety Inventory (STAI) was used to measure state levels of anxiety in all 100 patients. The scale was developed by Spielberger (Spielberger, Gorsuch, & Lushene, 1970) with a reliability coefficient of .92. The wording

of the directions of the scale was altered to focus attention on anxiety connected with the abortion (see Appendix B). The measure consists of 20 statements, designed on a Likert-type rating scale. The range of possible scores for the A-State form of the STAI varies from a minimum of 20 to a maximum score of 80.

The inventory has previously been used and proven reliable in other studies concerned with correlating levels of anxiety and obstetrical problems and previous abortion studies. Everett and Schechter (1971) used the STAI to distinguish whether married women who were pregnant had higher levels of anxiety than women pregnant out of wedlock. Findings indicated that women pregnant out of wedlock were significantly more stressed and had higher levels of anxiety than pregnant women who were married. Anxiety was found to significantly correlate with abnormalities in pregnancy by Gorsuch and Key (1974) by use of the STAI as a measure of anxiety. Fingerer (1973) administered the STAI to abortion patients to determine the degree of anxiety that accompanied the abortion. Findings indicated that there was no immediate anxiety after the abortion, but possibly some mild depression. Lees (1975) used the STAI to test anxiety levels in male partners who accompanied their female partners to an abortion clinic and found that the men in the sample were much more anxious than normal populations or

men hospitalized for medical or psychiatric reasons.

The A-State form of the STAI took 5-10 minutes to complete. Each patient was administered the test immediately prior to the abortion procedure.

The Abortion Attitude Scale (AAS) is a 30 item, 5-point summated rating scale developed by Snegroff (1976) designed to determine each patient's positive (in favor) or negative (against) attitude toward abortion (see Appendix C). The attitude scale continuum ranges from a score of 150 (completely favorable) to a score of 30 (completely unfavorable). The scale has previously been used with a sample of undergraduate students at Brooklyn College. A reliability coefficient of 0.91 has been computed for the scale by the split-halves method (Snegroff, 1976). Content validity was achieved by compiling 300 statements that correspond to relevant content areas of the attitude system, as exemplified by the literature and by professionals in abortion and health (sex) education programs. Through a tedious process of elimination, 30 statements represent the final scale. The AAS was administered prior to surgery along with all other test instruments and took 5-10 minutes to complete.

The Dyadic Adjustment Scale (DAS) was administered prior to surgery. This scale assesses relationship adjustment of marital or nonmarital dyads. The scale for dyadic adjustment includes subscales which measure four conceptually

and empirically verified components: dyadic satisfaction, dyadic consensus, dyadic cohesion, and affectual expression. The final scale consists of 32 items, most of which are scored on 6-point scales, with a possible range of scores from 0-151. Content, criterion-related, and construct validity have been established by the author (Spanier, 1976). The DAS took 5-10 minutes to complete (see Appendix D).

A demographic questionnaire was administered to all patients in the study during their preabortion counseling sessions. This questionnaire contained data on age, education, marital status, religion, occupation, residence, and race. In addition, questions exploring the duration of the relationship and cohabitation were included (see Appendix E). Age and religion were correlated with the woman's abortion attitude. All remaining socio-cultural variables were used for descriptive data. A mean score for all patients was computed in reference to the duration of the relationship and cohabitation. The questionnaire took approximately five minutes to complete.

Procedure

In accordance with standard clinic procedure, patients entered by appointment, were randomly assigned to a trained abortion counselor, and were given an instructional package and medical consent form. A counselor, a woman, who conducted the counseling sessions and administered the

questionnaire was available five days per week. At the time of the private, preoperative counseling session (immediately after all forms were complete), the investigator informed the patient of the present study and asked the patient for voluntary participation. If the patient responded affirmatively, she completed the consent form to act as a subject. In addition, the patient was asked if her male partner was present or absent. There was a principal investigator and seven assistants, all trained, professional abortion counselors at the clinic, conducting the research. Assistants were briefed privately on ethical concerns of research and were instructed on administering the tests in compliance with procedure stated earlier. When the counseling session was over the patient was given the demographic questionnaire, the A-State form of the STAI, the Abortion Attitude Scale, and the Dyadic Adjustment Scale in randomized order. Immediately following the completion of the questionnaires, the patient was taken to the lab area for a routine check of vital signs. Following this, the patient was taken to the surgery room for her abortion. Before the abortion procedure began, patients were given nitrous oxide at a flow rate of 5 or 6 liters per minute. The patients breathed free-flowing nitrous oxide which ranged from 40% - 50% oxygen. In addition, patients were injected with a synthetic narcotic, Sublimaze, which produces feelings of

euphoria and deep muscle relaxation. The effects of this fast-acting drug lasted 30 minutes. The effects of the nitrous oxide were removed by administering 100% oxygen immediately following the surgery. The entire abortion procedure took eight to ten minutes to complete. Following surgery, the patients remained resting on the operating table for 10-15 minutes. A nurse then escorted the patient to the Recovery Room. After recuperating in the recovery area and after all effects of the drug had completely worn off, approximately 20 minutes had passed. The patients were given routine post-operative instructions and any contraceptive media they desired. In addition, participating patients were given a written de-briefing (see Appendix F). Patients were then released from the clinic's care.

CHAPTER III

RESULTS

Table 1 shows the mean responses and standard deviations for the A-State scale of the STAI, the AAS, and the DAS. For the A-State scale of the STAI, the abortion patients' mean score of 43.98 was significantly higher than the norms for General Medical and Surgical patients (42.38) as reported by Spielberger, Gorsuch, and Lushene (1970). A one-sample t test was computed to determine significance between means, t (99) = 3.04, $p < .05$.

TABLE 1

MEAN SCORES AND STANDARD DEVIATIONS FOR THE A-STATE SCALE OF THE STAI, THE DAS, AND THE AAS

	N	Mean	SD	Possible Range
A-State	100	43.98	5.27	20 - 80
DAS	100	105.44	25.93	0 - 151
AAS	100	118.92	13.65	30 - 150

For the Dyadic Adjustment Scale, the abortion patients' mean scale score was 105.44. Mean scores from the original sample reported by Spanier (1976) for both married and divorced persons indicated a total mean scale socre of 101.5.

A one-sample *t* test indicated that the means did not differ significantly, t (99) = 1.52, $p > .05$. In the original sampling conducted by Spanier, the mean score for married persons was 114.8 and divorced persons 70.7. No information was provided by Spanier on cohabitating couples.

The abortion patients' mean scale score on the Abortion Attitude Scale was 118.92. The mean scale score for the original sample of 527 undergraduate students was 116.6 as reported by Snegroff (1976). Due to unequal variances between groups, the appropriate test used to compare means was Welch's Approximation to the *t* test. The means were not significantly different, t (276) = 1.28, $p > .05$. The abortion patients' mean scale score of 118.92 falls almost halfway between 90 (undecided) and 150 (fully in favor) indicating a generally liberal attitude.

Table 2 displays the correlations obtained for all variables. Since the woman's anxiety, as measured by the STAI, and her perception of her satisfaction and adjustment with the male partner involved, as measured by the DAS, are both continuous variables, the Pearson Product-Moment Correlation was used to determine the measurement of relationship between the two variables. As seen in Table 2, the analysis yielded a correlation of .024. Fisher's *Z*-transformation and a one-sample *z* test indicated no significant difference, $Zr = .024$ and $z = .24$, $p > .05$. No

TABLE 2

POINT-BISERIAL, PEARSON PRODUCT-MOMENT, AND OMEGA SQUARED CORRELATIONS AND SIGNIFICANCE TESTS FOR ALL VARIABLES

VARIABLE	ANXIETY	AGE	RELIGION
DAS	.024 z=.24 NS		
PRESENCE OR ABSENCE OF MALE PARTNER	.115 t=1.15 NS		
ATTITUDE	.20* z=2.03	.021 z=.21 NS	-.012 NS

*$p < .05$

significant relationship was noted between the woman's anxiety level and satisfaction/adjustment in the relationship with the male partner involved in the pregnancy. Women with a high degree of dyadic adjustment were not significantly more or less anxious than women with a low degree of dyadic adjustment.

The presence or absence of the male partner is a dichotomous variable; therefore, the Point-Biserial was used to correlate the male's presence or absence with the woman's anxiety level, as measured by the STAI. The correlation of .115 was not significant as tested by a one-sample t test, t (98) = 1.15, $p > .05$. No significant relationship

was indicated between anxiety and the partner's presence or absence. The variables are unrelated.

The woman's attitude toward abortion, as measured by the AAS, is a continuous variable; therefore, the Pearson Product-Moment Correlation Coefficient was used to determine the measurement of relationship between the woman's anxiety level, as measured by the STAI, and abortion attitude. The analysis yielded a correlation of .20 which only accounts for 4% of the variance. Fisher's Z-transformation and a one-sample z test indicated a significant correlation with $Zr = .203$ and $z = 2.03$, $p < .05$. Abortion attitude does appear to be related to anxiety. Interestingly, women with more positive attitudes were significantly more anxious than women with more negative attitudes.

Pearson's Product-Moment Correlation Coefficient was used to determine if the woman's age was related to her abortion attitude. As Table 2 illustrates, the analysis yielded a correlation of .021. Fisher's Z-transformation and a one-sample z test indicated no significant difference, $Zr = .021$ and $z = .21$, $p > .05$. The results suggest that no significant relationship exists between a woman's age and her attitude toward abortion. Younger women were no more or less likely to have positive abortion attitudes than were older women.

The Omega Squared statistic (Hays, 1973) was used to determine the strength of the association between the woman's attitude, as measured by the AAS, and her religion. Due to 75% of the sample falling into the Protestant faith, religion was divided into three groups: Protestant, Non-Protestant, and None. The Non-Protestant (NP) group included the following religions: Catholic, B'ahai, Unitarian Universalist, Buddhist, and Non-Denominational. Table 3 shows the one-way Analysis of Variance computed between abortion attitude and religion. The correlation (-.012 as seen in Table 2) was not significant as tested by Omega Squared. Therefore, the results suggest that no significant relationship exists between an abortion patient's attitude and her religion. Protestants (P) were no more likely to have positive or negative abortion attitudes than were Non-Protestants or women with no religious designation.

TABLE 3

ONE-WAY ANALYSIS OF VARIANCE OF ATTITUDE SCORES AND RELIGION

Source	df	Sum of Squares	Mean Squares	F-ratio
Between groups	2	149.1135	74.5568	0.395
Within groups	97	18304.2492	188.7036	
Total	99	18453.3630		

Table 4 displays the demographic variables (marital status, religion, income level, type of hometown, ethnic group, and highest grade of school completed) and their frequencies (percentages are the same as frequencies since n = 100). The mean age for all 100 abortion patients was 23.82, the median age was 23.25, and the most frequently occurring ages were 20, 22, and 24 with an equal number of patients in each age group. As Table 4 illustrates, the modal class for marital status was single. The modal class for religion was Protestant. The Non-Protestant (16%) breakdown consisted of Catholic (12 patients) and one patient in each of the following religions: B'ahai, Unitarian Universalists, Buddhists, and Non-Denominational. There was no modal class for income level. The annual income ranges of $7500 - $10,000, $10,000 - $12,500, and $12,500 - $15,000 all had equal frequencies of 15 patients per group; therefore, the majority of the sample earned between $7500 and $15,000 annually. The median response for income level was $13,175. The modal class for type of hometown was a large city and for ethnic group the modal class was white which seems related to the location of the clinic. As for schooling, the modal class was 12th grade or GED. The median response was two years of college. All but ten of the 100 patients had completed high school, four patients had completed 10th grade, three completed 11th grade, and

TABLE 4

DEMOGRAPHIC CHARACTERISTICS

MARITAL STATUS	FREQUENCY
Single	56
Married	20
Divorced	16
Widowed	1
Separate	7

INCOME LEVEL	FREQUENCY
Under $5000	8
5000-7500	8
7500-10,000	15
10,000-12,500	15
12,500-15,000	15
15,000-17,500	13
17,500-20,000	6
Over $20,000	19

SCHOOLING	FREQUENCY
Under 12	10
12 or GED	28
1 yr. coll.	9
2 yr. coll.	18
3 yr. coll.	7
4 yr. coll.	12
4½ yr. coll.	1
5 yr. coll.	1
6 yr. coll.	1
Grad School	7
Vocational	1
College - no indication of years	5

RELIGION	FREQUENCY
Protestant	75
Non-Prot.	16
None	9

HOMETOWN	FREQUENCY
Large city	45
Suburb of large city	17
Small city or large town	23
Small town	11
Rural	4

ETHNIC GROUP	FREQUENCY
White	83
Black	15
Chicano	1
Oriental	1

AGE	FREQUENCY
16	1
17	3
18	7
19	7
20	10
21	6
22	10
23	8
24	10
25	6
26	7
27	5
28	5
29	3
30	2
31	3
32	2
33	2
35	1
36	1
38	1

three were in the 12th grade.

For women whose male partners were present, the mean length of time that the women had been going with the man involved in the pregnancy was 35.08 months with a standard deviation of 38.08 as seen in Table 5. It is apparent that a wide range of scores were reported since the standard deviation is larger than the mean. As can be seen in Appendix G (total list of all variables), the range of answers to length of time gone together for women whose male partners were present started with 0 (not really going together, two women) and ended with going together up to 12 years. As for length of time lived together, 22 of the 50 women whose male partners were present did not live together. Of the 28 who did live together, the mean length of time was 33.36 months with a standard deviation of 38.28 (see Table 5). Again a wide range of responses were reported with a continuum ranging from 1 month to 12 years.

For women whose male partners were absent, the mean length of time that the women had been going with the man involved in the pregnancy was 14.12 months with a standard deviation of 18.78 as seen in Table 5. Ten of these women considered themselves not really going together by responding with 0. Again, a wide range of answers were reported varying from 0 to 6 years as can be seen in Appendix G. As for length of time lived together, 43 of the 50 women whose

TABLE 5

MEANS, STANDARD DEVIATIONS, AND SAMPLE SIZES FOR GOING TOGETHER AND LIVING TOGETHER COUPLES SEPARATED BY PRESENCE OR ABSENCE OF MALE PARTNERS

	N	Mean	SD
Present Male Partner/ Gone Together	50	35.05	38.08
Absent Male Partner/ Gone Together	50	14.12	18.78
Present Male Partner/ Lived Together	28	33.36	38.28
Absent Male Partner/ Lived Together	7	14.71	13.52

male partners were absent did not live together. Of the seven who did, the mean length of time was 14.71 months with a standard deviation of 13.52. The seven women responded with answers ranging from one month to three years.

As tested by a one-sample t test, women whose male partners were present had gone together significantly longer than women whose male partners were absent, t (49) = 5.50, $p < .05$. Also, women whose male partners were present had lived together significantly longer than women whose male partners were absent. Welch's Approximation to the t test indicated a significant difference, t (29) = 2.11, $p < .05$.

Of the three women who agreed to participate in the study but did not complete the questionnaires, three different issues accounted for their reluctance. One began to answer the questions but due to an inability to understand a majority of the words decided to withdraw her responses. Another withdrew halfway through the testing and announced that she really did not have a relationship. The third individual answered one questionnaire then chose to withdraw without any willingness to explain. Approximately eight to ten patients refused to participate in the study when approached.

CHAPTER IV

DISCUSSION

The findings of this study were contrary to what had been hypothesized. The results indicated that (1) no significant relationship existed between the woman's anxiety level and satisfaction/adjustment in the relationship with the male partner involved in the pregnancy, (2) no significant relationship was found between the woman's anxiety and the partner's presence or absence, (3) women with more positive abortion attitudes were significantly more anxious than women with more negative attitudes; and (4) no significant relationships existed between the woman's abortion attitude and her age or religion. Additionally, after data was collected it was tested and discovered that for women whose male partners were present, these couples had gone together significantly longer and had lived together significantly longer than women whose male partners were absent. There are several possible explanations for why the results reported above were obtained.

First, although the anxiety scores for the 100 patients were significantly higher than norms reported for general medical and surgical patients, the difference was small (1.60) which is statistically significant, but not practically significant. In contrast, the patients' scores were

not as high as one might expect for individuals presently in an intense physical and emotional situation in which their decisions will effect the rest of their lives. The testing process was administered after an individual counseling session with a trained abortion counselor. Therefore, if the therapeutic intervention of the counselor was effective (even to a small degree), then all patients' anxiety levels would have been reduced prior to testing.

Second, when correlating abortion attitude with religion, a larger sample size might have shown significant results. As stated earlier 75% of the sample was Protestant and only 16% were Non-Protestant; therefore, justifying the division of Protestant and Non-Protestant rather than Catholic and Non-Catholic. Also, Catholics seem to be less likely to choose abortion. Perhaps a larger sample size would have obtained more diversity among religious groups; therefore, effecting abortion attitude. In addition, a self-selection process may be involved as those Protestants and Non-Protestants (including only 12 Catholics) who chose abortions as an alternative to an unplanned pregnancy would be much more likely to participate in an abortion study. Those women who would not choose abortion as an alternative are not included in this sample; therefore, a shortcoming in correlating religion with abortion attitude is noted. For this sample, overall abortion attitudes were on the liberal end of the continuum,

which is what one might have anticipated.

The timing of the data collection may have had an unexpected impact. The testing procedure was administered during a 3½ week period from the end of March through the middle of April. Coinciding with the data collection were the religious events of Lent and Easter. For Christians, particularly Catholic and Orthodox faiths, this holiday is the holiest time of the year. Women who were reared Catholic have been taught to honor this time of year and to attend services throughout Holy Week to show their respect and love for God. The awareness of Lent and the sense of family surrounding the Easter holidays may have accounted for the low number of Catholics in the study.

The results did not indicate that age was significantly related to abortion attitude. A possible reason for a lack of significant findings in regard to age could be that younger women in high school and college are now exposed to sex education on a more structured basis. Speakers on abortion and birth control are invited into the schools, youth groups, and runaway homes on a regular basis. Older women who were not officially instructed in school about birth control, childbearing, etc. have learned about these areas through experience, media, or hearsay. Assuming that younger women have had more exposure to sex education might account for non-significant differences when correlating age and abortion

attitude because younger and older women may have similar knowledge acquired through different means.

Third, the correlation between abortion attitude and anxiety was significant in the opposite direction predicted, i.e., women with more positive attitudes toward abortion also tended to be more anxious. It has been shown empirically that an increase in knowledge about abortion is related to a change in attitudes in a more positive direction (Snegroff, 1976). This group of women was fairly well-educated, with a large majority having some college. Even though the attitudes were positive with regard to abortion, their knowledge of possible complications was probably pretty extensive. Although it is speculative, the patients' anxieties were perhaps realistic rather than mythical; therefore, resulting in higher anxiety levels. In addition, the testing procedure was conducted at the end of an individual counseling session with the patient. Patient education on abortion is a routine facet of the counseling session. It can be speculated that each patient ended the counseling session knowing more about abortion than they did when they entered the clinic. Even the most informed individual on abortion may be excessively anxious due to fear of surgical risks. Future studies might combine a pretest period on abortion knowledge, abortion attitude, and anxiety. A patient education session would follow then a posttest period on all of the variables to determine

if more knowledge of abortion has a direct relationship with anxiety.

Another possible explanation is that women who were capable of expressing more positive attitudes about abortion may also have been more open to express their anxieties. Women with negative attitudes may have simply been less expressive individuals in the abortion counseling session.

Fourth, it was predicted that women who felt more positively about their relationship and felt as though it were a satisfying one would be more anxious because the abortion experience might have long-term implications for the relationship. In spite of the diverse relationships reported, the overall mean adjustment score for all patients was fairly high indicating a high degree of dyadic consensus, satisfaction, cohesion, and affectional expression. Women whose male partners were present appeared to be in more solid and long-standing relationships than women whose male partners were absent. The mean length of time gone together for women with present partners was 35.08 months compared to 14.12 months for women with absent male partners. A one-sample t test of present/absent male partners and length of time gone together indicated that these groups differed significantly. Also, the mean length of time lived together for women with present male partners was 33.36 months compared to 14.71 months for women with absent male partners.

Again, these results were statistically significant.

As testing proceeded it became evident that the relationship systems of the women were more complicated than originally anticipated. As reported by the patients themselves, many confounding variables were present. For example, one patient was in the midst of a divorce, was very upset, and feared for her life. She was afraid her husband would cause her bodily harm if he found out about the pregnancy. The unborn was not his. She answered the DAS in regard to the man involved in the pregnancy, but her thoughts of him were overshadowed by her fear of her husband. Another example which occurred was the case of the single (sometimes married) woman whose partner was a man married to another woman. The intensity of the relationship with the male partner involved in the pregnancy may have been positive and strong, but could never succeed. Another instance concerned the woman who was separated from her husband when conception occurred (by another man) and at the time of the abortion her husband accompanied her to the clinic as they had reconciled. The woman received all the emotional support, reassurance, empathy, and concern she needed but from her husband, not the man involved in the pregnancy. Also, there was the patient who participated in a "one-night stand" and only knew the male partner for a few short hours. In this event, there is no relationship.

There was also the patient who had reached the decision to terminate the relationship when the abortion was completed. The woman not only was mourning the fetus, but also the relationship. Another case involved the patient whose common-law husband had been in a plane crash one year ago and had become dependent upon her. Her father also had a heart attack approximately the same time. The woman had several crises operating simultaneously and her anxiety was shared among her many problems. All of the above are examples of confounding anxieties and/or confounding relationships. The women may not have considered themselves in a relationship, may have been involved in competing relationships with competing loyalties, etc. Future studies might consider primary relationships that are stable, intimate, and exclusive. Perhaps a significant relationship would exist between anxiety and relationship satisfaction if extraneous variables such as were mentioned above did not exist.

Fifth, no significant relationship was found concerning the presence of the male partner and anxiety. The results of the study did not support the prediction that women whose male partners are present tend to be more anxious due to reverberating feelings. As was stated earlier, many women prefer that their male partners not accompany them and prefer counseling sessions which do not include the male

partner. Perhaps as abortion patients sit in the waiting room they tend to focus more exclusively on the surgical procedure and their own anticipation and defocus or tune-out their partner's verbal and nonverbal behavior. In contrast, it could have been that the mere presence of the male partner was anxiety reducing for emotionally dependent patients. Informal data reported by counselors who were testing indicated that this particular group of present male partners might have been exceptionally good at the art of deception and concealing their own anxietal states so that there was no reverberation of anxious feelings. Researchers might investigate the potential for deception and concealing to determine if these factors influence the woman. From abortion counseling experience, it has been noted that the male partners sometimes try to conceal their true feelings. Lastly, it may be that the trend of increased abortion availability, awareness, and consumption has lowered the anxious disposition of the population at large. The legalization of abortion may have allowed for its increased acceptance as a safe procedure with positive outcomes.

Although the results of this study were incongruent with what was hypothesized, the support system of the woman seeking abortion is still an important variable to consider. The woman and male partner are interdependent parts which characterize the relationship. The woman cannot be viewed

as an entity separate from her support system, as this would distort the picture. The woman may feel emotional pain, but it is through the support system that these emotional needs are largely met (Foley, 1974). It is possible that the effect of the support system on the woman may not be evident in anxiety levels, but may be related to sureness of decision or personality characteristics such as self-esteem, self-worth, autonomy, or emotional dependence. Future studies might examine the influence of the support system as it relates to the woman's personality.

Although the sample was biased in favor of volunteers, the information provided is still valuable for abortion researchers and providers. Future studies of abortion might attempt to assess the couple as a whole sometime after the abortion as well as on the day of the procedure to test the extent of association between women's anxiety levels and the couple's relationship. Another study identical to the present one with the exception of testing patients before counseling rather than afterwards might show more significant results. It would be helpful to test patients at several local clinics which use different types of anesthesia or no anesthesia to determine if anxiety is related to the idea of receiving some type of pain controlling medication. Perhaps patients who know they will be receiving anesthesia are less anxious overall than those patients

receiving little or no anesthesia.

A study might be generated by observing women who choose abortion clinics and women who choose to go to their private gynecologists for abortions. Finances may be a big determinant in this choice and perhaps personality characteristics enter into the decision. In other words, this choice is possibly related to personality which in turn may be related to anxiety levels. Also, it would be possible to determine if the unmarried woman is more likely to abort than the married woman. Regardless of whether the relationship is stable or satisfying, is being married enough to eliminate the option of abortion for some women? Researchers might interview women in health clinics and referral agencies such as Life Planning at the time of confirmation of pregnancy to establish the percent of married and nonmarried women who choose abortion. At the same time when pregnancy is confirmed, it is likely that this time marks the beginning of the decision-making process. Researchers might consider this time to observe and measure personality characteristics and anxiety levels in potential abortion patients and compare these scores to those obtained on the day of the abortion (for those women who choose abortion). Abortion providers might utilize this time of pregnancy confirmation to help the couples through the decision-making process. Lastly, an effort should be made to contact and study a

sample of couples who do not spontaneously come to the abortion clinic together. A comparison between this sample and a sample of couples who come to the clinic together may be more definitive in areas of relationship dynamics, support systems, anxiety, and abortion attitudes.

Reference Note

1. Boyd, G. H. Personal communication, February 4, 1980.

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APPENDICES

APPENDIX A

INFORMED CONSENT FORM

Our clinic is conducting a study to improve the focus of our counseling process and to provide broadened services. We would greatly appreciate your help. If you agree to help us, you will need to fill out some opinion questionnaires today.

There are no right or wrong answers. All we want to know is your honest opinion about each question.

Your responses are for statistical purposes and will be kept strictly confidential.

I agree to participate in the study and give my consent for the clinic to use the data I provide. I understand that my responses will be kept strictly confidential. I understand that it will involve the completion of questionnaires and that I may withdraw my data at any time. The investigation has been explained to me and I hereby authorize _____ to administer the investigation. I understand that my participation in this investigation will be a contribution to the inauguration of better services offered to abortion patients. I further understand that no medical service or compensation is provided to subjects by the university with which this study is affiliated as a result of injury from participation in research. An offer to answer all my questions has been made.

_____	_____	_____
Subject's Signature	Date	Witness

If you are a minor, please have your parent or legal guardian sign below.

_____	_____	_____
Signature of Parent or Legal Guardian	Date	Witness

APPENDIX B

A-STATE SCALE OF THE STAI

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel right now when you think of the abortion. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings at this moment best.

DATE: _____

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	(1)	(2)	(3)	(4)
2. I feel secure	(1)	(2)	(3)	(4)
3. I am tense	(1)	(2)	(3)	(4)
4. I am regretful	(1)	(2)	(3)	(4)
5. I feel at ease	(1)	(2)	(3)	(4)
6. I feel upset	(1)	(2)	(3)	(4)
7. I am presently worrying over possible misfortunes	(1)	(2)	(3)	(4)
8. I feel rested	(1)	(2)	(3)	(4)
9. I feel anxious	(1)	(2)	(3)	(4)
10. I feel comfortable	(1)	(2)	(3)	(4)
11. I feel self-confident	(1)	(2)	(3)	(4)
12. I feel nervous	(1)	(2)	(3)	(4)
13. I am jittery	(1)	(2)	(3)	(4)
14. I feel "high strung"	(1)	(2)	(3)	(4)
15. I am relaxed	(1)	(2)	(3)	(4)
16. I feel content	(1)	(2)	(3)	(4)
17. I am worried	(1)	(2)	(3)	(4)
18. I feel over-excited and "rattled"	(1)	(2)	(3)	(4)
19. I feel joyful	(1)	(2)	(3)	(4)
20. I feel pleasant	(1)	(2)	(3)	(4)

APPENDIX C

ABORTION ATTITUDE SCALE

DIRECTIONS: Read each statement. You are to place an X through the response that most closely corresponds to your own feelings about each statement. There are no correct or incorrect answers. Be sure to respond with your own feelings, and not as to how someone else would expect or want you to answer. Indicate the extent to which you agree or disagree according to the following scale.
SA - strongly agree, A - agree, U - undecided, D - disagree, SD - strongly disagree

1. Abortion penalizes the unborn for the mother's mistake.	SA	A	U	D	SD
2. Abortion places human life at a very low point on a scale of values.	SA	A	U	D	SD
3. A woman's desire to have an abortion should be considered sufficient reason to do so.	SA	A	U	D	SD
4. I approve of the legalization of abortion so that a woman can obtain one with proper medical attention.	SA	A	U	D	SD
5. Abortion ought to be prohibited because it is an unnatural act.	SA	A	U	D	SD
6. Having an abortion is not something that one should be ashamed of.	SA	A	U	D	SD
7. Abortion is a threat to our society.	SA	A	U	D	SD
8. Abortion is the destruction of one life to serve the convenience of another.	SA	A	U	D	SD
9. A woman should have no regrets if she eliminates the burden of an unwanted child with an abortion.	SA	A	U	D	SD
10. The unborn should be legally protected against abortion since it cannot protect itself.	SA	A	U	D	SD
11. Abortion should be an alternative when there is contraceptive failure.	SA	A	U	D	SD
12. Abortions should be allowed since the unborn is only a potential human being and not an actual human being.	SA	A	U	D	SD
13. Any person that has an abortion is probably selfish and unconcerned about others.	SA	A	U	D	SD
14. Abortion should be available as a method of improving community socioeconomic conditions.	SA	A	U	D	SD
15. Many more people would favor abortion if they knew more about it.	SA	A	U	D	SD

16. A woman should have an illegitimate child rather than an abortion.	SA	A	U	D	SD
17. Liberalization of abortion laws should be viewed as a positive step.	SA	A	U	D	SD
18. Abortion should be illegal, for the Fourteenth Amendment to the Constitution holds that no state shall "deprive any person of life, liberty or property without due process of law."	SA	A	U	D	SD
19. The unborn should never be aborted no matter how detrimental the possible effects on the family.	SA	A	U	D	SD
20. The social evils involved in forcing a pregnant woman to have a child are worse than any evils in destroying the unborn.	SA	A	U	D	SD
21. Decency forbids having an abortion.	SA	A	U	D	SD
22. A pregnancy that is not wanted and not planned for should not be considered a pregnancy but merely a condition for which there is a medical cure, abortion.	SA	A	U	D	SD
23. Abortion is the equivalent of murder.	SA	A	U	D	SD
24. Easily accessible abortions will probably cause people to become unconcerned and careless with their contraceptive practices.	SA	A	U	D	SD
25. Abortion ought to be considered a legitimate health measure.	SA	A	U	D	SD
26. The unborn ought to have the same rights as the potential mother.	SA	A	U	D	SD
27. Any outlawing of abortion is oppressive to women.	SA	A	U	D	SD
28. Abortion should be accepted as a method of population control.	SA	A	U	D	SD
29. Abortion violates the fundamental right to life.	SA	A	U	D	SD
30. If a woman feels that a child might ruin her life she should have an abortion.	SA	A	U	D	SD

APPENDIX D

DYADIC ADJUSTMENT SCALE

DIRECTIONS: Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Dis-agree
1. Handling family (mutual) finance	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behavior)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in-laws	5	4	3	2	1	0
10. Aims, goals, and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house (one another) after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married or lived together or started a relationship?	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0

	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas?	0	1	2	3	4	5
26. Laugh together	0	1	2	3	4	5
27. Calmly discuss something	0	1	2	3	4	5
28. Work together on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

29. Yes No Being too tired for sex.

30. Yes No Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

_____ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
_____ I want very much for my relationship to succeed, and will do all I can to see that it does.
_____ I want very much for my relationship to succeed, and will do my fair share to see that it does.
_____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
_____ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
_____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

INSTRUCTIONS:

Please remember that your answers are completely confidential. The whole success of a study like this depends on your answering these questions as carefully as you can. Your answers are important.

Most questions can be answered by checking (✓) one of the answers. If you do not find the exact answer that fits your case, check the one that comes closest to it, or write in your own answer.

Please feel free to write in any explanation or comments you may have right on the questionnaire.

If you have difficulty with any words or questions, please feel free to ask.

Questionnaire

1. Your Age: _____

2. Highest grade of school completed:
   ___Under 12th (Indicate number of grade _____)
   ___12th or GED
   ___College (1 year = 30 semester hours. Indicate years_____)
   ___Graduate School
   ___Other (Please specify: _____)

3. Please check one of the following:
   ___Single ___Widowed
   ___Married ___Separated
   ___Divorced

4. What religion are you?
   ___Protestant ___Other (Please specify:_____)
   ___Catholic ___None (If none, what religion were you raised in?
   ___Jewish _____)

5. Please mark your yearly income level (or your family's if you're a student or if you are living at home):
   ___Under $5000 ___$10,000 - $12,500 ___$17,500 - $20,000
   ___$5000 - $7500 ___$12,500 - $15,000 ___Over $20,000
   ___$7500 - $10,000 ___$15,000 - $17,500

6. Type of city or town you live in:
   ___Large city (400,000 or more) ___Small town
   ___Suburb of large city ___Rural
   ___Small city or large town

7. What ethnic group are you a member of?
   ___White (Caucasian) ___Native American ("American Indian")
   ___Black (Afro-American) ___Other (specify:_____)
   ___Chicano ___I prefer not to answer
   ___Oriental

The following are some questions about you and your male partner involved in this pregnancy.

8. How long have you gone together? (Be as specific as you can; put a "0" if you're not really going together):_____.

9. Do you two share a living space (House, apartment, etc?) Yes_____ No_____. If yes, how long have you lived together:_____

APPENDIX F

DE-BRIEFING

You have just participated in a study exploring anxiety in abortion patients. We are wondering if the people you are close to seem to be a help in times of stress. We wonder if couples tend to be anxious together. We also wonder if the abortion has put a strain on your relationship with the male partner involved and whether this strain tends to strengthen or weaken your relationship. We also are wondering if you feel more anxious about the abortion because you personally do not favor abortion, or does your attitude toward abortion make a difference in how anxious you are? Your participation in this study will help clarify many of these thoughts. The more information we obtain about women seeking abortion, the better able we will be to provide improved services for abortion patients and their partners. Once again, your responses are strictly for statistical purposes and no names will be used. We appreciate your help and assistance. If you are interested in the results of this study, you may phone the clinic at 742-9310 in June, 1980 for a brief description of the findings.

APPENDIX G

TOTAL LIST OF ALL VARIABLES

SUBJECT	MARITAL STATUS	INCOME LEVEL	HOME-TOWN	ETHNIC GROUP	SCHOOLING	GONE TOGETHER	LIVED TOGETHER
1	M	17.5-20	LC	W	12	6.5 yrs.	6.5 yrs.
2	S	5-7.5	SUB	W	2	4 yrs.	1 yr.
3	M	12.5-15	SUB	W	12	5 yrs.	5 yrs.
4	SE	7.5-10	SMT	W	11th	6 yrs.	No
5	M	10-12.5	LC	W	10	1 yr.	1 yr.
6	S	7.5-10	SMC	W	3	8 mos.	No
7	S	U 5	SUB	W	12	37 mos.	2 mos.
8	SE	7.5-10	SMT	B	10	6 yrs.	No
9	S	7.5-10	R	B	2	1 yr.	No
10	S	15-17.5	LC	B	10	1.5 yrs.	No
11	D	7.5-10	SUB	W	12	0	No
12	D	U 5	LC	W	Grad	13 mos.	1 mo.
13	S	7.5-10	LC	W	2	6 mos.	No
14	S	15-17.5	SUB	W	2	2.5 yrs.	No
15	D	17.5-20	LC	W	Grad	0	No
16	M	10-12.5	LC	W	12	6 yrs.	4 yrs.
17	S	5-7.5	SMC	W	2	3 mos.	No
18	S	12.5-15	SUB	W	3	3 mos.	2 mos.
19	S	U 5	SUB	B	10	4.5 yrs.	No
20	S	O 20	SMC	W	3	6 mos.	No
21	S	5-7.5	SMT	W	12	4 mos.	No
22	M	10-12.5	LC	W	10th	0	No
23	SE	12.5-15	SUB	W	4	2 mos.	No
24	D	O 20	SUB	W	2	0	No
25	S	U 5	LC	W	10th	7 mos.	1 mo.
26	S	O 20	SMT	W	10	3.5 yrs.	No
27	S	U 5	LC	W	12	7 mos.	No
28	D	U 5	SMT	W	11th	5 mos.	4 mos.
29	D	15-17.5	LC	W	4	6 mos.	No
30	M	10-12.5	SMC	W	2	8 yrs.	2 yrs.

SUBJECT	MARITAL STATUS	INCOME LEVEL	HOME-TOWN	ETHNIC GROUP	SCHOOLING	GONE TOGETHER	LIVED TOGETHER
31	S	17.5-20	SMC	W	10th	8 mos.	No
32	S	15-17.5	LC	W	4	6 mos.	No
33	S	O 20	SMT	W	11th	1 yr.	No
34	S	12.5-15	LC	B	2	1 yr.	No
35	D	12.5-15	LC	B	1	5 yrs.	No
36	M	17.5-20	SMC	W	3	10 yrs.	9.5 yrs.
37	S	O 20	SMC	W	12th	0	No
38	SE	15-17.5	SMC	W	12	0	No
39	S	7.5-10	LC	W	12th	1 yr.	4 mos.
40	S	10-12.5	LC	W	12	4 mos.	4 mos.
41	M	12.5-15	SMC	W	2	5 yrs.	4 yrs.
42	S	O 20	SMC	W	4	7 mos.	No
43	S	5-7.5	SMC	W	12	9 mos.	No
44	S	10-12.5	LC	W	1	3 mos.	No
45	S	12.5-15	SUB	W	12	0	No
46	M	17.5-20	SMC	W	1	1 yr.	4 mos.
47	S	12.5-15	LC	W	12	0	No
48	S	10-12.5	LC	W	12	0	No
49	M	O 20	SMT	W	Grad	4 yrs.	3.5 yrs.
50	SE	7.5-10	LC	W	12	6 mos.	No
51	D	12.5-15	LC	B	V	1 mo.	No
52	S	12.5-15	LC	W	3	5 mos.	No
53	M	O 20	SUB	W	12	3 yrs.	3 yrs.
54	S	12.5-15	LC	W	5	1.5 yrs.	3 mos.
55	D	5-7.5	SMC	W	2	6 mos.	No
56	S	15-17.5	LC	W	12th	1 yr.	No
57	M	O 20	LC	C	12	10 yrs.	9 yrs.
58	S	15-17.5	LC	W	1	9 mos.	6 mos.
59	S	U 5	SMT	B	12	2 mos.	No
60	M	O 20	LC	W	4	12 yrs.	12 yrs.

SUBJECT	MARITAL STATUS	INCOME LEVEL	HOME-TOWN	ETHNIC GROUP	SCHOOLING	GONE TOGETHER	LIVED TOGETHER
61	M	15-17.5	SMC	W	2	7 yrs.	6.5 yrs.
62	M	15-17.5	SMT	W	1	15 mos.	No
63	S	7.5-10	LC	W	12	1 yr.	8 mos.
64	S	O 20	LC	W	4	6 mos.	No
65	S	10-12.5	LC	W	2	1 yr.	2 mos.
66	SE	O 20	SUB	W	12	14 mos.	No
67	W	O 20	LC	W	2	1.5 yrs.	No
68	S	5-7.5	R	W	6	3 yrs.	3 yrs.
69	S	7.50-10	LC	B	1	0	No
70	D	O 20	SUB	W	3	8 mos.	No
71	S	10-12.5	SUB	B	1	4 mos.	No
72	D	10-12.5	LC	B	2	10 mos.	No
73	D	12.5-15	R	W	Grad	9 mos.	No
74	S	7.5-10	LC	W	1	7.5 yrs.	No
75	D	7.5-10	SMC	W	2	2 yrs.	2 yrs.
76	S	10-12.5	SMC	W	10th	8 mos.	8 mos.
77	S	10-12.5	LC	B	4	0	No
78	M	5-7.5	LC	W	Grad	2 yrs.	10 mos.
79	S	O 20	LC	W	4.5	6 mos.	No
80	S	15-17.5	R	W	3	12 yrs.	No
81	M	15-17.5	SMC	W	12	4 yrs.	3 yrs.
82	S	7.5-10	SMT	W	Grad	3 yrs.	1.5 yrs.
83	M	15-17.5	SMC	W	4	2 yrs.	1.5 yrs.
84	S	5-7.5	SMC	W	1	1.5 yrs.	No
85	SE	15-17.5	LC	W	12	8 mos.	No
86	S	17.5-20	SMC	B	4	7 mos.	No
87	S	O 20	SUB	W	12	3 yrs.	No
88	M	12.5-15	SUB	W	12	4 yrs.	3.5 yrs.
89	S	U 5	SMC	W	2	3 mos.	No
90	M	O 20	SUB	W	4	4 yrs.	2 yrs.

SUBJECT	MARITAL STATUS	INCOME LEVEL	HOME-TOWN	ETHNIC GROUP	SCHOOLING	GONE TOGETHER	LIVED TOGETHER
91	S	10-12.5	LC	O	2	4 yrs.	No
92	S	12.5-15	LC	B	Grad	10 mos.	No
93	D	7.5-10	LC	B	2	3 yrs.	2 yrs.
94	S	O 20	LC	W	12	7 mos.	No
95	S	10-12.5	SMC	W	4	6 mos.	No
96	S	7.50-10	SMT	W	12	3 yrs.	No
97	D	O 20	SMC	W	12	2 yrs.	No
98	S	12.5-15	LC	W	4	2 yrs.	No
99	D	7.5-10	LC	W	12	1 yr.	No
100	S	10-12.5	LC	W	12	0	No

KEY

Marital Status - S = Single, M = Married, D = Divorced, W = Widowed, SE = Separated

Income Level - U 5 = Under $5000, 5-7.5 = $5000-$7500, 7.5-10 = $7500-$10,000, 10-12.5 = $10,000-$12,500, 12.5-17 = $12,500-$17,000, 17.5-20 = $17,500-$20,000, O 20 = Over $20,000

Hometown - LC = Large City, SUB = Suburb, SMC = Small city or large town, SMT = Small town, R = Rural

Ethnic Group - W = White, B = Black, C = Chicano, O = Oriental

Schooling - 10th = Completed 10th grade, 11th = Completed 11th grade, 12th = In 12th grade, 12 = 12th or GED, 1 = 1 year college, 2 = 2 years college, 3 = 3 years college, 4 = 4 years college, 4.5 = 4½ years college, 5 = 5 years college, 6 = 6 years college, 10 = College years unknown, V = Vocational, Grad = Graduate School

SUBJECT	PARTNER	AAS	A-STATE	DAS	AGE	RELIGION
1	P	131	50	118	28	P
2	P	114	46	136	20	P
3	A	131	38	102	22	P
4	A	122	54	107	23	P
5	P	89	40	112	21	NP
6	A	101	31	122	20	P
7	P	127	41	129	18	P
8	A	113	43	46	25	P
9	P	114	48	123	19	P
10	A	97	45	125	20	P
11	A	117	46	35	30	None
12	P	131	43	120	29	None
13	A	131	43	133	23	P
14	A	93	40	116	28	P
15	A	121	42	82	38	P
16	P	121	39	123	22	P
17	P	117	41	126	20	P
18	A	140	52	87	24	NP
19	A	132	54	127	22	P
20	P	130	43	129	20	P
21	A	126	53	28	20	NP
22	P	105	42	107	29	None
23	A	111	42	109	23	P
24	A	111	46	121	22	P
25	A	134	31	121	19	P
26	A	113	51	90	19	P
27	P	101	45	45	18	P
28	A	119	42	80	26	None
29	A	109	39	106	32	NP
30	P	129	46	102	24	P

SUBJECT	PARTNER	AAS	A-STATE	DAS	AGE	RELIGION
31	A	105	40	113	16	P
32	A	109	45	113	23	None
33	A	126	45	124	17	P
34	A	110	38	101	26	P
35	A	83	41	31	31	P
36	P	112	46	110	27	NP
37	A	130	40	99	17	P
38	A	113	42	99	25	P
39	P	114	42	147	20	NP
40	P	119	48	134	20	P
41	P	121	35	109	26	P
42	P	115	45	128	21	P
43	A	122	42	123	21	P
44	A	127	48	97	18	P
45	A	127	47	78	18	P
46	P	111	42	128	21	NP
47	A	119	37	98	19	None
48	P	130	44	119	17	P
49	P	134	46	121	30	P
50	P	132	39	99	28	P
51	P	133	54	115	24	P
52	P	107	40	123	24	NP
53	P	118	52	99	21	NP
54	P	137	47	118	24	None
55	P	139	46	101	22	P
56	A	121	41	79	19	P
57	P	104	45	96	23	P
58	P	146	52	121	22	NP
59	A	98	45	96	20	NP
60	P	103	44	98	33	P

SUBJECT	PARTNER	AAS	A-STATE	DAS	AGE	RELIGION
61	P	111	48	111	24	NP
62	P	112	44	112	18	P
63	P	141	54	124	19	None
64	A	130	43	112	31	P
65	P	132	40	111	23	P
66	A	123	42	75	28	P
67	P	98	40	126	36	P
68	P	124	43	108	28	NP
69	A	93	44	63	26	P
70	A	139	38	121	31	P
71	A	103	39	48	27	P
72	A	110	46	119	27	P
73	A	134	42	80	33	NP
74	P	86	51	101	22	P
75	A	125	44	127	26	P
76	P	134	54	132	25	NP
77	A	98	37	55	26	P
78	P	128	45	124	27	P
79	P	127	42	123	29	P
80	P	122	53	137	21	P
81	A	116	39	110	22	P
82	P	113	51	110	25	P
83	P	115	41	123	27	P
84	P	126	43	105	25	P
85	A	142	47	92	25	NP
86	P	95	46	134	22	NP
87	P	118	34	136	18	P
88	P	121	56	102	24	P
89	A	120	45	94	20	P
90	P	122	36	113	24	P

SUBJECT	PARTNER	AAS	A-STATE	DAS	AGE	RELIGION
91	P	98	37	103	19	P
92	A	130	40	129	22	P
93	A	115	55	124	24	P
94	A	116	49	96	18	P
95	A	144	41	116	32	P
96	A	116	43	93	23	P
97	P	126	39	111	35	P
98	P	127	41	108	26	None
99	A	140	51	108	24	P
100	A	127	41	004	23	P

KEY

Partner - P = Present, A = Absent

Religion - P = Protestant, NP = Non-Protestant, None = No Religious Designation