

**NEGOTIATING VALUES IN ABORTION COUNSELLING**

**by**

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## **ABSTRACT**

The introduction of abortion legalisation in South Africa during 1997 gave rise to the need for pre- and post-abortion counselling. Two dominant counselling groups came to the fore namely pro-choice and pro-life, reflecting the respective stances of society on abortion.

In order to answer the following research questions: "What value-challenges do abortion counsellors experience, if any?" and "What ways have they found in negotiating these challenges?" A narrative conversation was used to come to an understanding of these research questions in practice. Research was undertaken with counsellors from both pro-life and pro-choice stances. The influence of capitalism, patriarchy and religion on role players confronted with making decisions on abortion was explored.

Pro-choice counsellors negotiated their values in terms of forgiveness based on the unconditional forgiveness they would expect from God and pro-life counsellors in terms of God's forgiveness for the client, accepting her own responsibility for the consequences of the abortion.

### **Key words**

Narrative pastoral counselling, values, abortion, pro-life, pro-choice, discourses, participatory research.

## PREFACE

I would like to dedicate this research to all women who have to make a choice when confronted with an unwanted or unplanned pregnancy. It took me this research study to realise how difficult that decision must be and how society contributes to this difficulty.

I would like to express my sincere appreciation to *all* the people who contributed to this research.

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# Negotiating values in abortion counselling

## Chapter One

### Setting the Scene

*I dream about the day when all children born were welcome and when sexuality is an expression of joy and caring.*

*Elise Ottesen-Jensen\**

#### 1. Introduction

The topic of abortion and family planning is and has been a sensitive and controversial social and moral issue throughout history for many nations and communities: "Induced abortion is one of the oldest and most controversial forms of fertility regulation. No other elective surgical procedure has evoked as much world-wide debate, generated such emotional and moral controversy, or received greater sustained attention from the public and the media" (David, Dytrych, Matějček & Schuller 1988:9).

Over the centuries counsellors, politicians, medical practitioners, formal and informal community leaders, religious denominations, families and family members have argued the moral and practical viewpoints of abortion from different perspectives to resolve the problem of unwanted or unplanned pregnancy. Riddle (1992:ix), in his book *Contraception and abortion from the Ancient World to the Renaissance* states:

We tend to believe that quandaries over birth control are recent, brought on by science and technology. In fact the human problems now are much the same as when Juvenal wrote almost two thousand years ago that 'we have sure-fire contraceptives'. Hundreds of generations have faced the same problems we do – saints and sinners, people in distress, kings, queens, merchants and peasants. Were we wise, we would learn from the past. At the very least, let us be consoled by the realization that our times are not as unique as we think they are.

The controversy about abortion still continues. In South Africa the controversy about abortion evolutionized over the previous decades where different people, religions, ethnic groups and governments demonstrated different stances on abortion. Recent pro-choice legislation further polarized the pro-life and pro-choice debate. People, who support a pro-life stance, campaign for the rights of the unborn foetus, while pro-choice proponents campaign for the freedom of choice for women. Counsellors as well as clients' values also resonate with the different views of this debate. The values as well as how counsellors negotiate these were the prominent focus of this research.

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\*Ottesen-Jensen (quoted in David, Dytrych, Matějček and Schuller 1988:7)

The client, faced with the unwanted or unplanned pregnancy also subscribes to specific values. Abortion is often associated with the term "unwanted pregnancy". According to David et al (1988:25) the term "unwanted pregnancy" may have a variety of possible meanings in different psychosocial contexts. The meaning may depend on the circumstances of the woman – did she want a child at the time of conception? Socio-economic circumstances may play a role – would she be able to afford a child? How many children does she already have? Personal reasons may influence the meaning of the term for example the woman's desire to finish her education or pursue a career. These above-mentioned aspects as well as the woman's inherent values have to be negotiated in addressing the unwanted pregnancy.

Counsellors and clients with their respective values meet each other in the realm of the counselling situation. Negotiating their values simultaneously while addressing the unwanted pregnancy is the challenge addressed in this research.

## **2. Purpose of research**

My purpose with this research was to inquire about the moral value challenges experienced by counsellors and to determine the ways they have created to deal with these challenges. In this research study I focussed on specific value questions regarding abortion from the perspective of counsellors. I used narrative pastoral practice to question, deconstruct and investigate ideas regarding abortion and values.

In this chapter I offer a formulation of the research question. I define the research question in terms of a research domain as well as the methodology I use in this study.

The research was addressed by formulating it in terms of specific research questions stated in the next paragraph.

## **3. Research Question**

I wondered whether counsellors might face a dilemma in abortion counselling regarding their own value systems and that of the client's. I became curious as to how counsellors address this dilemma they might face during abortion counselling. In order to find possible answers as to what challenges counsellors' experience, I formulated the following research questions:

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

Abortion, abortion counselling and the underlying values in the South African context, with a strong patriarchal basis, has evolved over time according to the influences of legislation. Legislation specified counselling to woman requesting abortion. I present how legislation led to the establishment of counselling institutions with reference to the value negotiation implications. The evolvement of legislation in this context and its influence on negotiating values, are presented in the next paragraph.

Following the presentation on legislation a research methodology is defined that would be applicable and related to the research question.

#### **4. Legislation on abortion in South Africa**

##### **4.1 General**

Legislation in South Africa allowing abortion *under certain circumstances* was introduced in 1975 (Abortion and Sterilization Act No. 2 of 1975). This legislation should be considered against the background of the socio-political background of the time. South Africa was at that stage in many respects isolated from the rest of the world and was to a large extent regarded by the outside world as a "police state". It was to be expected that the state would dictate the circumstances and context in which abortions would be allowed. Similarly, when the "new" democratic South Africa came about in 1994, it was to be expected that freedom of choice of the individual (woman) would play a more significant role.

##### **4.2 Abortion and Sterilization Act No. 2 of 1975**

The Abortion and Sterilization Act No.2 of 1975 defines the "circumstances in which an abortion may be procured on a woman or in which a person who is incapable of consenting or incompetent to consent to sterilization, may be sterilized; and to provide for incidental matters."

The Abortion and Sterilization Act No. 2 of 1975 states:

3. **Circumstances in which abortion may be procured.** – (1) Abortion may be procured by a medical practitioner only, and then only-
  - (a) where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy so endangers the life of the woman concerned or so constitutes a serious threat to her physical health an abortion is necessary to ensure the life or physical health of the woman;
  - (b) where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned, and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy creates the danger of

permanent damage to the woman's mental health and abortion is necessary to ensure the mental health of the woman;

- (c) where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped, and two other medical practitioners have certified in writing that, in their opinion, there exists, on scientific grounds, such a risk; or
- (d) where the foetus is alleged to have been conceived in consequence of unlawful carnal intercourse, and two other medical practitioners have certified in writing after such interrogation of the woman concerned as they or any of them may have considered necessary, that in their opinion the pregnancy is due to the alleged unlawful carnal intercourse;
- (e) where the foetus has been conceived in consequence of illegitimate carnal intercourse, and two other medical practitioners have certified in writing that the woman concerned is due to permanent mental handicap or defect unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus.

The Abortion and Sterilization Act, No .2 of 1975 defines abortion as "the abortion of a live foetus of a women with intent to kill such foetus." The implication of this wording could have made woman feel that even though they would qualify for an abortion the connotation would be murder.

Some groupings in society felt that this law discriminated against women who were illiterate and could not interpret the law. It is questionable whether this criticism was valid, as it could also apply to all other legislation and literature that illiterate people do not have access to. It does, however, indicate the need for propagating the rights of individuals as contained in legislation, something provided more fully in subsequent legislation (see paragraph 4.4 below).

### **4.3 Consequences of the Restricted Abortion Act No. 2 of 1975**

Due to the restrictions of Act No.2 of 1975, (Abortion and Sterilization Act No. 2 of 1975), women had to find means to accommodate unwanted pregnancies. The fact that abortion was not legally available to all women lead to illegal back-street abortions.

A study published in the South African Medical Journal (Venter 2000) estimates that 44 686 women were treated for incomplete abortions in public hospitals during 1994. One should take into account that in 1994 abortion was not yet fully legalised in South Africa. Of this number of women who were treated, 445 died mainly of infection due to the incompleteness of the abortion as well as a lack of knowledge regarding the aftercare following an abortion. The medical costs for treating these patients during 1994 were conservatively estimated at R18,7m.

The "struggle" for the legalisation of abortion was mainly to provide holistic woman-friendly reproductive health services appropriate to women's needs and for these services to be accessible to all women (women of all cultures, classes and racial backgrounds). According to an article, *Preventing suffering and death – a rational abortion policy for South Africa*, published by the Reproductive Rights Alliance (2001), legalisation of abortion provides circumstances in which safe abortions can be carried out, including counselling in an environment that provides women with information to prevent future abortions. Pro-choice campaign argue that if a friendly trusting environment, where safe abortions can take place, could be established, women would feel comfortable to come back to talk about their rights, their bodies, contraception and other reproductive health services (Reproductive Rights Alliance 2001).

Abortion was fully legalised in South Africa in 1997 and The Choice on Termination of Pregnancy Act No. 92 of 1996 was promulgated on 1 February 1997. This legislation should also be considered against the provision of the constitution of the country which allows, amongst others, both for the "right to life" (Section 11) and "to make decisions concerning reproduction" Section (2)a (Constitution 1996). With reference to "right to life", Williams (2000b) states that laws prohibiting abortion are made because abortion results in the death of a living human being (the foetus) that has a right to life or, "somewhat more precisely, a right not to be killed." Williams argues that the foetus is deprived of the same right as already born human beings not to be killed. This difference raises the question of the ethical and legal status of the foetus and contributes to different stances in society towards abortion.

The Choice on Termination of Pregnancy Act No. 92 of 1996 did not replace the Abortion and Sterilization Act No. 2 of 1975, but is an amendment to restrictions that were previously placed on the circumstances under which an abortion could be obtained.

#### **4.4 Choice on Termination of Pregnancy Act No. 92 of 1996**

The Choice on Termination of Pregnancy Act No. 92 of 1996 aims to "determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith."

### **2. Circumstances in which and conditions under which pregnancy may be terminated.**

- (1) Pregnancy may be terminated-
  - (a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

- (b) from the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-
  - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
  - (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
  - (iii) the pregnancy resulted from rape or incest; or
  - (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or
- (c) after the 20<sup>th</sup> week of the gestation period if a medical practitioner, after consultation with another medical practitioner or registered midwife, is of the opinion that the continued pregnancy-
  - (i) would endanger the woman's life;
  - (ii) would result in a severe malformation of the fetus; or
  - (iii) would pose a risk of injury to the fetus.

The Act defines termination of pregnancy as follows: "...the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant women." In using this more acceptable wording and description of abortion, this Act does not imply connotations to life or death, murder or killing of the foetus.

#### **4.5 Consequences of the Choice on Termination of Pregnancy Act of No. 92 of 1996**

Although abortion has been legalised in South Africa since 1996, some people still have moral issues on abortion.

In the article *Medics refuse to perform abortions – back-street abortions rife as 166 clinics take moral stand*, Taitz (2000b) reports: "Nearly two-thirds of the public facilities designated to provide free and legal abortions are not functioning because doctors and nurses refuse to assist with the procedure for moral reasons or are afraid of harassment from members of their communities." Following on this situation, other reports indicate that health workers claim that they are frequently overlooked for promotion because of their willingness to perform abortions (Taitz 2000b). The paradox facing the abortion issue is that the law gives women the right to have an abortion, but that the constitution gives health workers the right to refuse to perform abortions.

Apart from moral objections from medical practitioners against abortion, ignorance and financial constraints contribute to back-street abortions – ignorance in the sense that there are still women who do not realise that abortion has been legalised and available to them. De Lange (2000) quotes a Department of Health

study [s.a] indicating that 47% of women were not aware that abortions were available on request up to twelve weeks. The study shows that 60% of women in the Northern Province, Eastern Cape and Northern Cape were unaware of the new abortion legislation.

Some women cannot afford a legal abortion. The cost of an abortion can range from R300-00 to R1000-00 depending on the physical location of the abortion clinic (Marie Stopes 2001). According to a spokesperson that wishes to remain anonymous at a Pro-Choice Clinic (Anonymous 2001a) white women undergo abortions during the first trimester of pregnancy while black women, due to financial issues, in the second trimester of pregnancy. Taitz (2000b) argues that it is poor, black women living in rural areas who are least likely to have access to abortions.

Though an abortion at a government hospital is done free of charge, long waiting lists occur due to the fact that only a limited amount of abortions is being carried out daily. The long waiting list contributes to the fact that these women have to undergo abortions in a late stage of gestation – more than twelve weeks. At this stage of gestation the foetus is already in an advanced state of development that not only makes the abortion procedure more difficult but also causes moral issues with medical practitioners (Althaus 2000).

Ignorance, financial constraints and attitudes of medical workers as discussed above contribute to back-street abortions. Many women feel that if they go to hospital with an incomplete abortion they will get better treatment than requesting an abortion at an approved hospital. These incomplete abortions again contribute to patients arriving haemorrhaged at hospitals that are often staffed by pro-life professionals. These doctors and nurses are professionally obliged to complete the second part of the abortion procedure. "Japie Alant, a junior doctor, testified: 'Myself, and many of my colleagues, being objectors towards any facilitation of the termination of pregnancy process, were on occasion forced to violate our conscience in order to ensure proper care for these mothers'" (Taitz 2000a).

Towards the end of the 1980's, in the United States of America, a foetus had more legal rights than a child, leaving the woman with almost no right:

As the foetus's rights increased, mother's just kept diminishing. Poor pregnant women were hauled into court by male prosecutors, physicians, and husbands. Their blood was tested for drug traces without their consent or even notification, their confidentiality rights were routinely violated in the state's zeal to compile a case against them, and they were forced into obstetrical surgery for the 'good' of the foetus, even at risk of their own lives.

(Faludi 1991:424)

Even today people who oppose abortion still only take the rights of the foetus into consideration and do not consider the rights of the mother or her body. "While those who oppose abortion count the costs to the unborn, those who support it count the costs to the living" (Taitz 2000a).

Although many women might feel that abortion is private and if they should make use of a public hospital everyone would know about the abortion. According to Popo Maja (Venter 2000), spokesperson for Gauteng Health Department, pregnant women *and* society should be educated to realise that abortion is a woman's right.

In South Africa "the curriculum for doctors does not include abortion and only certain doctors, midwives and nurses are allowed to perform this procedure" (Venter 2000). Moreover, accessibility to professional care is further hampered by the misconception that any qualified doctor can perform an abortion.

On the other hand, between February and December 1997, 26 406 safe abortions were carried out in South Africa. Notwithstanding complaints, the attitudes of medical staff and women seeking abortion too late, these "problems" are now less a matter of structure than of education and training. (Hilton-Barber 1998)

In contrast with this positive statement of abortion the following notice was placed in Pretoria News (Death notices 2000):

**All BABIES**

Killed by abortion since 1 February 1997. Africa Christian Action mourns over 142 812 (Source: Dept. of Health) babies whose lives have been tragically cut short since the legislation of abortion-on-demand.

May God have mercy on South Africa.

"Speak up for those who cannot speak for themselves." Proverbs 31:8.

For further information info please contact (021) 689 4487

*Pretoria News* 1 February 2001

#### **4.6 Impact of legislation on counselling**

Legislation made counselling for abortion candidates mandatory and opened the opportunity for various support groups to be established. Pro-Choice and Pro-Life are two prominent support groups that came to the fore and are discussed in more detail.

#### **4.6.1 Pro-Choice**

Pro-choice proponents believe that a woman should be able to choose whether to continue with a pregnancy or not. They claim that if she decides that a termination of pregnancy is in her and her family's best interest that she should have access to counselling and a safe and legal abortion service that could be provided by these Pro-Choice Clinics.

At these clinics the individual's right to privacy, dignity, confidentiality as well as religious and cultural beliefs are always respected. At the Pro-Choice Clinic in Pretoria, qualified nursing specialists do the counselling and perform the abortion.

At these Pro-Choice Clinics, abortion is only performed on women who are totally willing and convinced of their decisions. The counselling that clients receive prior to the procedure includes a stipulation that they must agree to a recognised method of contraception before they leave the clinic, as termination of pregnancy is not seen as a form of contraception or population control (Choice on Termination of Pregnancy Act No. 92 of 1996).

The aims of the Pro-Choice Clinics are to prevent unwanted births and to afford women the right to have children by choice not by chance.

The first Pro-Choice Clinic in South Africa was established in 1994 in Central Johannesburg. Until abortion was fully legalised in 1997 this clinic functioned as a family planning clinic. Services included sterilisation as a form of contraception. Since 1997, this Pro-Choice Clinic has expanded and currently has eleven clinics situated in Gauteng, Kwazulu Natal, the Free State, Western Cape and Mpumalanga. The services provided include: Safe abortions, vasectomies (male sterilisation), counselling, pap smears, ante-natal check-ups, gynaecological check-ups, female sterilisations, pregnancy tests, HIV-tests and the distribution of condoms, contraceptives in the form of pills, injections and emergency contraception.

#### **4.6.2 Pro-Life**

The first Pro-Life Clinic was established in 1993 since no facilities existed where a woman, faced with an unwanted pregnancy, could go for information and help. According to a spokesperson at a Pro-Life Clinic, (Anonymous 2001b) most pregnant women who face an unwanted pregnancy experience panic, anger, fear and feels lonely and depressed. One of the aims of Pro-Life Clinic is to reach out to these women in love and compassion.

The Pro-Life Clinic is a non-profitable organisation, staffed by trained, supervised volunteers and funded through donations by the public and churches. It forms part of a national non-racial networking body called SA Cares for Life, offering caring services to men, women and children in South Africa. Another aim of Pro-Life Clinics is to prevent women from making rushed decisions regarding their unwanted pregnancy by "giving them balanced, non-manipulative information; placing equal value towards mother and baby" (Neo Birth Pregnancy 2000).

Pro-Life Clinics provide the following services: a free pregnancy test, information on foetal development, information on abortion, information on alternatives to abortion for example single parenthood, marriage and adoption; counselling as and if needed with the client's parents, boyfriend or husband, information on all legal aspects surrounding the rights of the client, the biological father and the baby; introduction to a doctor or clinic for good medical care an information on how the client can continue with school, university or her job; live-in accommodation in a pregnancy care home can also be arranged for the client as well as help and guidance in all pregnancy-related areas. The Pro-Life Clinics provide personal counselling for as long the client might need it. The client is provided with both antenatal and post-natal guidance, maternity clothes is supplied as well as babies clothing and equipment if the client decides to keep the baby. These clinics provide a unique Christian adoption service if the client's circumstances should warrant an adoption.

Post-abortion counselling is also available if the client has undergone an abortion or has suffered a miscarriage. Any assistance, depending on the particular circumstances and needs of the client, is offered at the Pro-Choice Clinic.

The opposing views supported by pro-life and pro-choice campaigners, will influence abortion counselling – the stance of the counsellor toward abortions as well as his or her own values and value systems will influence the way in which abortion counselling is done.

#### **4.7 The right of women and the backlash**

In 1996 abortion has been legalised in South Africa only to be opposed again in July 1997 by three anti-abortion groups, challenging the constitutionality of the new law on the grounds that it violated the rights of the foetus. The law remained in effect during the legal proceedings, however a year later the Pretoria High Court ruled against the challenges (Althaus 2000).

The backlash of abortion legislation comes to the fore in the medical profession in many ways. Medical health workers refuse to perform abortions because of moral reasons (Taitz 2000b). This refusal forces women to seek back-street abortions, confirming that their freedom to choose becomes no freedom at all.

Availability of physical locations where abortion can be done is restricted and not always accessible to women living in rural areas. Another complicating factor is that not enough midwives have been trained clinically and theoretically to perform abortions. Though the South African Nursing council has approved a curriculum, plans for integration have yet to be drafted (Althaus 2000).

An organisation such as Pro-life confirms the backlash in South Africa in the sense that they have a fundamentalist religious stance that abortion is wrong, murder and a sin. Counselling is done according to these beliefs, be it pre- or post-abortion counselling. This religious stance places the client in a situation where she feels condemned even though she has the freedom to choose.

Another religious backlash South African women are experiencing is from political organisations such as the ACDP (African Christian Democratic Party) who objected to the "supremacy of the South African Constitution over God's law" (12 reasons 2001). The South African Constitution approve the right "to make decisions concerning reproduction" Section (2)a and the ACDP oppose this "right" saying: "The ACDP rejects this attempt to licence the slaughter of innocent and defenceless children" and "We reject exposing present and future generations to abortion slaughter-houses" (12 reasons 2001).

The backlash as discussed above indicates that although abortion has been legalised, issues like values have still to be negotiated and will be addressed in this research.

#### **4.8 Legislation and the research question**

Legislation led to the establishment of Pro-Life and Pro-Choice as counselling institutions with their underlying values. The backlash as discussed above also accentuates the value issue. The background on legislation, counselling institutions and the backlash situation confirms and supports the research questions as defined in paragraph 3. These are:

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

The research methodology applicable and related to the research question is discussed in the next paragraph.

## **5. Research methodology and scope definition**

### **5.1 Introduction**

Research methodology has to be suited to address the key issues related to the research questions and present the researcher with the possible answers to the research questions. The chosen research methodology is discussed in the next paragraphs.

### **5.2 Selection of a research methodology**

For the purpose of this study, I have chosen a feminist research approach because feminist research is concerned with transforming women's conditions by means of research that is *for*, *by* and *about* women (Stacey 1988:21). I regard abortion a feminist issue because it has to do with women in a specific situation where choices regarding their own bodies and reproductive rights have to be made. In this specific research the participants are women with different perspectives of abortion, perspectives that affect the lives of women who are faced with unwanted pregnancy.

Although I am aware of male issues involved in abortion, I am also aware that males dominated abortion for too many years to be yet again centralized, excluding the voice of the female researcher and female participant. With this statement I do not imply that men should be excluded in the abortion issue, as it was a man Bill Baird "father of abortion rights" that saw the need of women facing unwanted pregnancy that made the way for women to be able to have a choice regarding their unwanted pregnancy (Shostak, McLouth and Seng 1984:163).

The male issues involved in abortion holds certain discrepancies as Shostak et al (1984:153) states: "A man has no rights as partner in the decision to abort or carry to term, but many responsibilities as father if she carry the foetus to term". In spite of the above-mentioned male issues involved in abortion, for the purpose of this research study a feminist research methodology was chosen and specifically, contemporary feminist ethnography.

### **5.3 Contemporary feminist ethnography**

Contemporary feminist ethnography is characterised by egalitarian relations that require authenticity, reciprocity and intersubjectivity between the researcher and the researched. This research method allows women to study women in an interactive process (Stacey 1988:22). In contemporary feminist ethnography research the researcher (a woman) is the primary instrument of research. The advantage is that women can apply resources of empathy, connection and concern that are needed in a feminist issue such as abortion.

Another important aspect in contemporary feminist ethnography research is respect. Wheatley (1994:403) states that respect between the researchers and participants are of utmost importance and they have to be treated as collaborators in the research process.

According to Reinharz (1992:51) contemporary feminist ethnography has the following three goals:

### **5.3.1 Documenting the lives and activities of women**

Documenting lives and activities of women allows the researcher to be a participant observer of women in areas where they act as full members of their social, economic, and political worlds. The researcher becomes a part of women's lives and this enables the researcher to "put diverse groups of women on the social map, and sometimes use interviews to understand the perspective of individual women" (Stall in Reinharz 1992:52).

### **5.3.2 Understanding the experience of women from their own point of view**

Understanding the experience of women from their own point of view eliminates interpretations from the perspective of men in society or the male researcher that holds a non-feminist view. Hammersley (in Williams 1993a:578) stresses that the "experience" of women is given primacy in feminist research. She refers to experience "as a product of 'sustained observation' and 'listening to' the accounts of 'others'." Enslin (1994:543) states: "Feminist researchers celebrate the knowledge gained from feeling and experience in everyday life."

### **5.3.3 Conceptualise women's behaviour as an expression of social context**

To understand women in context is described by feminist ethnographers as trying to "interpret women's behaviour as shaped by social context free or rooted in anatomy, personality, or social class" (Reinharz 1992:53). Contemporary feminist ethnography's approach to knowledge is contextual and interpersonal and therefore includes the realm of everyday reality and human agency (Stacey 1988:22).

One of the characteristics of contemporary feminist ethnography is participant observation. It was through this participant observation that Faye Ginsburg (in Reinharz 1992:53) came to understand that the purpose of women with a pro-life or pro-choice stance was to support other women in the context of their own values that go along with the values of the community or society that they live in.

For the purpose of this research study, the above-mentioned goal, conceptualising women's behaviour as an expression of social context in contemporary feminist ethnography, is used.

## **5.4 Practical application of the feminist ethnography research methodology**

### **5.4.1 Understanding women's context**

By using narrative conversations, I conducted interviews with counsellors from two different organisations. Rejecting the "hierarchical, objectifying, and falsely 'objective' stance of the neutral, impersonal interview as neither possible nor desirable" (Stacey 1988:22), I conducted these interviews keeping in mind that "meaningful and feminist research depends instead on empathy and mutuality" (Stacey 1988:22). I was aware that I had to constantly reflect on my own stance, values and value systems towards abortion. The latter resonates with Heshusius's idea of participatory consciousness. Participatory consciousness reflects a way of being in the world which is characterised by "allocentric" knowing. Allocentric knowing requires an attitude of profound openness and receptivity towards the other, a temporarily "let go" of all preoccupations with the self and a move into a state of complete attention. Turning to the other does not result in loss of the self, but leads to a heightened feeling of aliveness and awareness (Heshusius 1994 : 16-17).

Though equality was one of the objectives of the research, I was aware that the research interview position of a researcher could connote authority (Kauffman 1992:187). The fact that I was going to write about the interviews placed me in a power position. Due to possible inequality that the interviews and writing could bring about, I used the following to counter this possibility:

- a) I obtained written permission from the counsellors to conduct the interviews and write about the interviews.
- b) During the interviews I checked my understanding of the conversations with the counsellors to make sure that my understanding correlated with what they were saying during the interview.
- c) I e-mailed the written interviews to the participants to make sure that what they shared with me was correctly transcribed.
- d) I wrote a letter to the Pro-Life counsellors, reflecting on my understanding of my conversation with them as well as reflecting on the questions that I was left with after the first interview.
- e) Before I scheduled a second interview with the counsellors, I faxed the letter to them, using this written letter as a conversation document during my second interview with the counsellors.
- f) In the letter of consent the counsellors were given opportunity to access any part of the research at any time.

#### 5.4.2 Critique on contemporary feminist ethnography

Contemporary feminist ethnography as a research methodology is not without deficiencies and I was fully aware of the advantages and concerns about this research methodology to ensure accountability.

Firstly, some concern could be raised on the research *process*. In this regard Stacey (1988:21) states that feminist ethnography depends on human relationship, engagement and attachment and it places research participants at grave risk of manipulation and betrayal by the researcher. Enslin (1994:545) confirms that contemporary feminist ethnography can in some ways exploit participants. Opposing these statements Weathly (1994:404) argues that the issues of manipulation and betrayal by the researcher should rather be considered as ethical and epistemological concerns. She further states that: "As such, they need not be sources of feminist angst, but might be understood as inherent features of all research that involve theoretically and contextually specific decisions."

I regard the ethical responsibility of my research as paramount. The above-mentioned arguments left me with even more ethical responsibility towards the participants. I can associate with Enslin's (1994:545) critical questions: "Who speaks? Who writes? Who reads? Which women is this research for? Which 'women' benefit from knowledge of women's words?" By answering these questions, the researcher would be able to reflect on the ways of doing research in an ethical way as well as being accountable during and after the research process.

In the research I conducted, I aimed to be accountable for what and how I asked, said, wrote and read. In order to be accountable I had to be self-reflective before, during and after my interviews with the various counsellors. I also had to be transparent towards the counsellors I interviewed. I gained from Elliot (1998:45) that positioning oneself in relation to certain ideas, for example a pro-life or a pro-choice idea, involves taking a stance for those ideas. As the research progressed, I experienced being challenged in different ways.

Secondly, the *product* of contemporary feminist ethnography is being questioned – "With very rare exceptions it is the researcher who narrates, who 'authors' the ethnography. In the last instance an ethnography is a written document structured primarily by a researcher's interpretation, registered in a researcher's voice" (Stacey 1988:23). In questioning the product of research, Stacey introduces limitations on what can be studied, on what could be written – limitations that could seriously harm women's interests.

I consider Stacey's (1988:23) argument questionable since contemporary feminist ethnography strives to obtain an egalitarian and collaborative relationship between the researcher and the researched or participants. It should also be kept in mind that contemporary feminist ethnography is a participatory

research practice aiming to equalise the power difference between the researcher and participants. However, I was aware that power sharing was limited. In the light of the above, I realised that even though I invited collaboration into this project, it was not a fully participatory research project. Whereas in participatory research power, questions, aims and ways of reaching the aims are shared from the formulation of the research question up until where the written product is presented. I did not use such a power-sharing model (Bishop 1996) though partial sharing of power took place and I was committed to transparency, self-reflectiveness, accountability and being ethical in the research process as described by Elliot (1998:51-55).

To ensure accountability and transparency regarding the *product* of contemporary feminist ethnography, I want to stress that "what I am about to say does not represent the totality of what can be, is being, or has been done with regard to positioning in therapy" [or research in this case] (Elliot 1998:46).

### **5.4.3 Interviews with counsellors**

In order to find possible answers to the posed research questions, I approached the interviews with the following as guidelines:

- (a) Before conducting the interviews I introduced myself to the Directors of the different organisations and explained the goal of my research study. I obtained the Directors permission to interview the counsellors of their organisations. (Refer Annexure A).
- (b) Written permission was obtained from the counsellors to participate in the research as well as written permission to use the information gained during the interview for the goal of the research. (Refer Annexure B and C).
- (c) Written permission was obtained to write about the research. (Refer Annexure D).
- (d) After conducting the interviews with the counsellors, a letter was written to them, summarizing and reflecting on the interviews. (Refer Annexure E).
- (e) After conducting the interviews, the stories were written down by way of identifying categories, themes and patterns that had been derived from them. This was done with the research questions in mind, describing the outcome of the research questions.

### **5.5 Scope of the research**

The research scope in addressing the research question were formulated as follows:

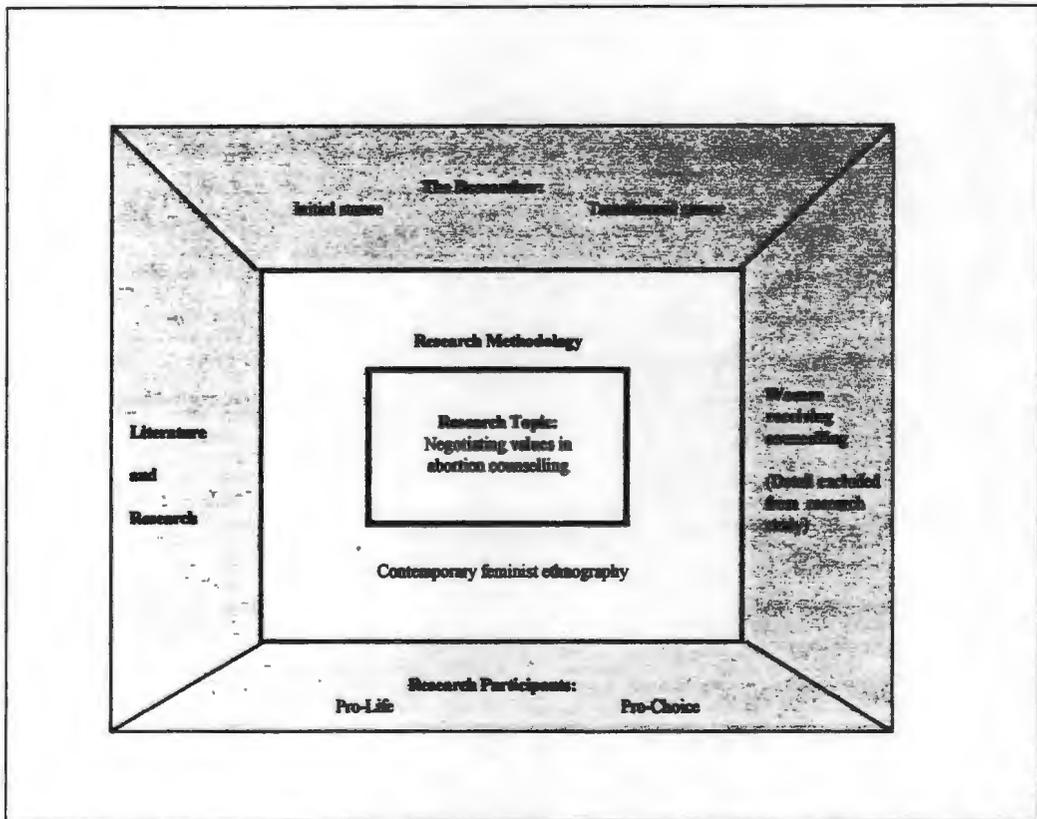
- a. Contemporary feminist ethnography as research methodology was applied.
- b. Research interviews were focussed on Pro-Life and Pro-Choice counsellors only.
- c. The woman facing the unwanted pregnancy, the male partners and the parents, were excluded.
- d. Literature related to the research question was studied and is presented.

The presentation of the above-mentioned scope is structured and discussed in the next paragraphs.

## 5.6 Next steps

The next five chapters in this research study cover related issues regarding "Negotiating values in abortion counselling."

**Diagram 1:** Schematic diagram of the areas of this research.



In order to come to a better understanding of the abortion debate and dilemmas created around this debate, it was necessary to look at the social construction of abortion, abortion discourses and the deconstruction of these discourses. These are discussed in chapter two.

As this research study addresses the challenges that counsellors face regarding values and value systems, these issues are addressed in chapter three. Chapter three also addresses ethics and the accountability that counsellors face in counselling and the influences of the values of the counsellor on the client and visa versa.

Chapter four consists of interviews with the Pro-Life counsellors and my subsequent reflection on the interviews.

In chapter five I discuss and reflect on the interviews conducted with the Pro-Choice counsellors and include my reflection thereof.

Chapter six consists of the research outcomes and the reflections on the research questions. I reflect on the method I used to conduct the research study as well as literature consulted. Reflection includes my own learning and growth during the research as well as reflection on my responsibilities regarding the research outcome.

## Chapter Two

### Social construction of abortion, discourses and deconstruction

#### 1. Introduction

Throughout history, women always found ways in dealing with unwanted pregnancies. Difficulties for women started when contraceptives were not freely available and abortion became illegal. (Corffman & Richardson 1993-1996) Working women had to cope with pregnancy and childcare with little support from employers. In earlier years (and even today) employers did not provide facilities, for example, day care centres for children. Financially women did not earn salaries equal to men. In the United States of America, pregnancy and childcare put women in an even more vulnerable position – that of losing their jobs because of “fetal protection policies” (Faludi 1991:435). In 1936 a woman writing to the *Working Woman* remarked that “working class” woman find life one long problem. But I think the most terrible one of all is the constant fear of more babies. I have three already, the eldest is just four and now I discover there is to be a fourth” (Trainor 1988:49). On the other hand, non-working women built their identities around their husbands and children; this again strengthened the patriarchal discourse. (Trainor 1988:51).

The following quote by Harrison (quoted in Neugar 1995:126) indicates the “invisible ways” women had to find in dealing with unwanted pregnancies: “Women’s way of meeting the challenges of fertility, pregnancy and childbearing is a most basic dimension of the true human story, even though it has been invisible in the tales of dominant histories...” The effect of unwanted pregnancies only became visible when women died of back-street abortions. In the 1930’s in New Zealand one in five pregnancies were aborted and the deaths resulting from abortion were one quarter of the total deaths associated with pregnancy and birth (Trainor 1988:49).

Since discourses in society are often “invisible”, I will discuss in this chapter the social construction of abortion, discourses and deconstruction of discourses regarding abortion.

#### 2. Post-modern discourse

A post-modern discourse challenges the notions of objective truth, fixed meanings, absolute knowledge and grand narratives. Instead a post-modern discourse emphasises the experience of multiple realities – that the individual constructs a narrated reality as perceived by him or her. This implies that every individual has the ability to reconstruct alternative narratives of his or her reality (or problem) when and if given an opportunity through deconstruction of discourses (Epston 1994).

In order to understand the ways in which different realities are constructed, social construction will be discussed in the following paragraphs.

## **2.1 Social construction**

### **2.1.1 Defining social construction**

According to Burr (1995:2) there is no single feature whereby social construction can be defined. However, the following elements are encapsulated in social construction:

### **2.1.2 A critical stance towards taken for granted knowledge**

A critical stance towards taken for granted knowledge implies that one should be suspicious of (modernist) assumptions about objective truth, fixed meanings, absolute knowledge and grand narratives. With reference to abortion this implies that every woman's experience of an unplanned pregnancy and of abortion is different and there can be no hard and fast rule in the abortion debate.

A modernist perspective of "truth" is based on the understanding that "real truth" is what is true everywhere, the universal and objective "truth". Brueggeman (1993:5) captures the spirit of the modernist perspective – "knowledge consists in rational, logical coherence, discerned by a detached, disinterested, disembodied mind ... knowledge comes from what is experiential, empirical, and factual." A modernist understanding of abortion would draw on the "universal and objective truth" and would therefore be able to see abortion as sinful – as murder.

In a post-modern world the "old modes of knowing ... no longer command respect and credibility as objective and universal truth" (Brueggeman 1993:8). Knowledge and knowing have become contextual and local. It has become impossible to voice universal truth from local knowledge.

With reference to abortion, objective truth, fixed meanings, absolute knowledge and grand narratives informed the dominant voices that were able to pose their view and to gain either assent or docile acceptance from those whose interests the truth claim did not serve. The abortion laws of the past being a case in point. These laws were made by men and the (male dominated) church – not by women who were faced with the consequences of these laws.

### **2.1.3 Historical and cultural specificity**

Burr notes (Burr 1995:3): "The ways in which we commonly understand the world, the categories and concepts we use, are historically and culturally specific." This statement implies that our understanding of the world in which we live, is derived from "when" and "where" we live. A practical example in the abortion

debate is where abortion was acceptable and not considered a murder or offence up until the 20th century when it was first classified as a sin by the Roman Catholic Church following laws by the state, declaring abortion illegal (Trainor 1988:48). Abortion legislation in South Africa has reflected and still reflects this historical and cultural specificity.

#### **2.1.4 Knowledge is sustained by social processes**

People construct knowledge among themselves. Knowledge is socially constructed: "It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated" (Burr 1995:4). What we therefore regard as 'truth' "is a product not of objective observation of the world, but of the social processes and interaction in which people are constantly engaged with each other" (Burr 1995:4). A practical example of knowledge that became fabricated by the interaction between people is the discussion of abortion by Roman Catholic Church leaders (men) and by members of parliament as well as the medical profession, deciding on the value issues and the "truth" of abortion.

The social construction of knowledge takes place primarily through language. Meaning is constituted in language and therefore it should be used with continuous self-reflection. Since counselling, as a form of language constitutes meaning, the counsellor's self-reflection will open opportunity to question the effects of his or her counselling on the client. The discourse of language and how it constitutes people is addressed in this chapter.

#### **2.1.5 Gaining of knowledge leads to social action**

With reference to paragraph 2.1.4 that social processes sustain knowledge, the following example confirms that knowledge leads to social action. With the awareness that during 1994, 44 686 women were treated for incomplete abortions (Venter 2000) and that back-street abortions were claiming the lives of many South African women, social action had to take place. This action was in the form of the revision of the existing abortion act (Abortion and Sterilization Act No. 2 of 1975) and abortion being legalised in 1996 (Choice on Termination of Pregnancy Act No. 92 of 1996).

Oakley and Mitchell (1997:167) state that in Italy during 1978 an estimated two million illegal abortions took place and that thousands of women died as a consequence.

The awareness of the affects of illegal, back-street abortions that eventually lead to legislation confirms Burr's statement that one of the pillars of social construction is that knowledge and social action go together – "each different construction also brings with it, or invites, a different kind of action from human

beings" (Burr 1995:5). Awareness of back-street abortions and its consequences became instrumental to the revision of abortion legislation.

## **2.2 Social construction of abortion**

As mentioned in chapter one, abortion is not a recent phenomenon. Neither has the understanding of abortion as murder dominated history in a philosophically or theologically way. In the early church abortion was not approved of, but neither was it seen as murder (Neugar 1995:126). The following gives a brief overview of the social construction of abortion.

## **3. Historical overview of abortion**

### **3.1 An international historical overview**

It seems that abortion is not the contemporary issue one sometimes might think. Contraceptives and abortifacients were available in ancient times. A Chinese inducing recipe for abortion appears in a medical book of herbal remedies dating back to 2737-2696 BC (David et al 1988:10).

Up to the eighteenth century most people wanted large families because the infant death rate was very high. It was not until 1798 that the British economist, Thomas Malthus, predicted that the human species would some day outstrip its capacity to feed itself. As medical care, nutrition, sanitation and work conditions improved and the death rate began to drop, more attention was given to birth control (Coffman & Richardson 1993-1996). Early efforts to provide birth control to women were met with resistance in the form of religious and individual opposition. In 1873, the United States Congress enacted the Comstock Law, which regulated public access to birth-control devices and information for the next sixty years. This prohibition, which made it illegal to distribute any device, medicine, or information designed to prevent conception, applied even to physicians.

In 1896 the Roman Catholic Church determined that abortion was murder and that members of the Roman Catholic Church were not to use contraceptives (Trainor 1988:48).

During the nineteenth century, first the English parliament and then American state legislatures prohibited induced abortion to protect women from surgical procedures that were regarded unsafe at the time, commonly stipulating a threat to the woman's life as the sole exception to the prohibition (Levy, Tietze & Means 1993-1996). Contraception was seen as a practice that would only increase the immorality of people, especially woman (Trainor 1988: 49).

During the 1950's both the church and medical institutions in Britain stated that sexual intercourse was not to be separated from procreation and that women were not to marry unless they were prepared to have children. "The state, the church and medical institutions preached that sexual intercourse was not to be separated from procreation; women were not to interfere in the 'natural process'..." (Trainor 1988:49). The first birth control clinic in Britain was opened in 1953. Women had to prove that they were married before they could buy contraceptives as contraceptives were only made available to married couples and was only to be distributed by medical practitioners and medical clinics.

In classical antiquity, there was no condemnation of abortion. Ancient Greeks used abortion to regulate their population and to maintain stable social and economic conditions. Plato (400 B.C.) recommended abortion to women over the age of forty and Aristotle recommended abortion to limit the size of families. Hippocrates was not in favour of abortion but occasionally recommended it by prescribing violent exercises (David et al 1988:10).

Rome did not impose legal restriction on abortion. The Roman Empire believed the foetus was part of the woman's body and that she could request its removal.

With the fall of the Roman Empire and the rise of Christianity (AD70) as well as in the Dark Ages and the Middle Ages, women managed nearly every aspect of fertility regulations. This was done on their own without the help of men, medical practitioners or professionals. "That midwives procured abortions clandestinely is apparent from the references to severe penalties imposed for the practice of inserting stems into pregnant uteri" (David et al 1988:10).

### **3.2 South African Historical Overview**

In South Africa, during the eighteenth century, many slaves did not want to bear children who would be born into slavery and many slave women ended their pregnancies. When the British colonised the Transkei in the nineteenth century they found that abortion was practised widely. It was practice for both Xhosa and Afrikaner women to use herbs to end early pregnancies. Coloured women used herb mixtures compiled by Pedi men to induce abortions. As missionaries came to South Africa, women were told that abortion was a "terrible sin" (Reproductive Rights Alliance 2001).

As the number of abortion cases increased during the Great Depression in the 1930's, so did the debate on whether abortion should or should not be legalised. Though birth control clinics were established, abortion was still illegal and contributed to illegal back-street abortions. An article published by The Reproductive Alliance (Reproductive Rights Alliance 2001) states that there was an average of one death a week from

illegal abortions in Johannesburg between 1959 and 1964 and in the 1970's one in three pregnant women throughout the world had an abortion. During the same period (1959 –1964) it was estimated that 100 000 back-street abortions were being performed per year.

Although abortion was legalised in South Africa in 1996, various groups (some medical practitioners and anti-abortionist campaigners) are still lobbying against the legislation.

The legislation of abortion in terms of The Choice on Termination of Pregnancy Act No. 92 of 1996 was “born” out of the need for the safety of woman's lives. Due to the restrictions of the Abortion and Sterilization Act No. 2 of 1975, many women died as a result of back-street abortions, or were left with no option as to continue with the pregnancy whether or not her circumstances, physically, emotionally or materially allowed it or not.

### **3.2.1 The influence of perspectives on quickening and ensoulment on abortion**

Controversy still exists as to when the soul enters the foetus, baby or person. Arguments include that the soul enters the foetus at conception, or when the baby or foetus breathes cool air or when the first movement is felt (quickening) (Riddle 1992:21-23). Judaic religious law allowed for a period of up to thirty days before a foetus was potentially viable and a woman was not regarded pregnant until forty days after conception.

Abortion is not mentioned in the Bible, though early Christians, following Judaic views, condemned abortion. However, abortion was not considered as murder before quickening or movement is felt (David et al 1988:11). According to Segal (2001) Old Testament laws stated (Exodus 21:22-23) if a woman suffers a miscarriage as a result of a struggle between men, a monetary compensation has to be paid to the woman's husband. If the women would die as a result of the miscarriage, the law states, “thou shall give life for life.” Interpretation and language plays an important role in the understanding of punishment of abortion in the Old Testament. In the Septuagint it is stated, “if there is no *form*, then the he shall be fined...but if it has form, then you shall give life for life” (Segal 2001).

The Roman Catholic view held that a male foetus receives his soul on the fortieth day after conception and a girl on the eightieth day. “Since the gender of all fetuses was, to the naked eye, physically indistinguishable until about the fourth month, all could be claimed to be female and so could be aborted until the eightieth day without committing murder” Whitney (in Neuger 1995:126-127). This idea was held by the church as well as by society for many centuries.

In Muslim society it is believed that the soul comes to the "conceptus" at the end of 120 days (Riddle 1992:126). Though Muslims generally accept this view, there are different interpretations. Hanafi jurists (during the thirteenth century) permitted a woman to abort before 120 days, even without the husband's permission.

According to literature David et al (1988:11), no major religion or denomination, with exception of the Roman Catholic Church, has a unified position on the matter of induced abortion. In 1869, Pope Pius IX in his *Constitution Apostolicae Sedis*, made a change in church law by eliminating any distinction between a formed and unformed foetus in meting out the penalty for abortion, even if it was to save the life of the woman.

### **3.2.2 Views on quickening in the United Kingdom**

From 1307 till 1803 women were allowed abortion in the United Kingdom. It was not considered an offence if it was done with the permission of the women and before the first movement of the unborn child was felt. An abortion after quickening was considered a misdemeanour (David et al 1988:11).

During the reign of George III (1760-1820), Lord Ellenborough's Act made procurement of abortion before quickening a felony with severe public punishment – even exile for up to fourteen years. Procuring an abortion after quickening was considered murder and was punishable by death.

European views on the restriction of abortion were spread by the colonial powers throughout Africa and Asia. "The strict prohibitions of Spain are reflected in many statutes promulgated in South America. In numerous countries of Asia and Africa, restrictions remained in force after independence had been gained, and were continued even after the departing Colonial Power had liberalized its own statutes" (David et al 1988:12). The implications of the "spreading of the colonial powers", led to foreigners rendering services to women even though they were not familiar with women's traditions.

Under the reign of George IV (1820-1830), the act was modified and supplanted during the reign of Queen Victoria. The act stated that surgical abortion at any state of pregnancy was a criminal offence, punishable by life imprisonment.

### **3.2.3 The United States of America-perspective**

The first abortion law in the United States was passed in 1821. This law restricted the provision of any substance or surgical abortion, before quickening. According to David et al (1988:12), this legislation was

introduced to preserve the life and health of the mother and the concern was not with the "unquickened" foetus. In some hospitals one operation in every three ended in death.

However, abortion sanctions in the United States seemed ineffective. In spite of abortion laws, abortionists were performing abortions publicly. Women considered abortion before quickening their right and the notion of sin did not arise until well after 1869. Illegal abortions were only discovered when they ended in disaster. The demand was of such a nature that not even the occasional convictions suppressed the practice of abortion.

New York legislators placed the abortion statute in the Penal Code instead of the Medical Practices Act. (David et al 1988:13). The medical profession realised that abortion could be a vehicle through which they could strengthen their professionalism in the medical profession.

### **3.2.4 Licensing of medical practices in the United States of America**

After the founding of the American Medical Association in 1847, organised drives were gradually launched to professionalise medical training and health service and to obtain legal and public acknowledgement of the professional status of physicians (David et al 1988:14). The physicians were mostly white non-immigrant, middle and upper middle class men who were attempting to upgrade the quality of the medical profession.

In order to become licensed practitioners, these physicians had to demonstrate that the work they were doing, had more credibility than practitioners as homeopaths and midwives. The only way in which this could be done was through opposing abortion, claiming to be saving the lives of women. "Unlike the other medico-moral issues of the time (alcoholism, slavery, venereal disease and prostitution) only abortion gave physicians the opportunity to claim to be saving human lives" (Luker quoted in Neugar 1995:127).

Between 1860 and 1880, most of the American states recognised the American Medical Association as the primary arbiter of medical and training practice. With this recognition, traditional quickening doctrines, common-law immunities for pregnant women were revoked.

### **3.2.5 Current legal situation**

Legalisation of abortion only began in the twentieth century (David et al 1988:17). Statistics suggest that about 76 percent of the world's five billion people live in countries where the dangerous practices of self-induced abortion or termination of pregnancy by untrained persons have been replaced by the growing

availability of legal abortions, performed safely, rapidly and at relatively low cost on broad health, eugenic, juridical, or social grounds by trained personnel in hospitals or free-standing clinics.

By 1954 abortion was illegal in all countries of the world with the exception of Iceland, Denmark, Sweden and Japan. In subsequent years more than thirty countries, including South Africa, changed their formerly restrictive laws or policies to permit abortion on request or on a broad range of social indications. The relaxation of abortion laws in diverse countries with different socio-cultural heritages can probably be traced to three interrelated reasons, firstly, a general recognition of the threat of illegal abortion to women's health, secondly, support for women's right to terminate an unwanted pregnancy under safe conditions at an early state of gestation and thirdly, provision of equal access to abortion for rich and poor women alike.

### **3.2.6 Reflecting on the social construction of abortion**

Reflecting on the social construction of abortion I was struck by the silence of women's voices regarding a feminine issue, an issue that affects woman in totality. Decisions on, and legalisation of abortion were made by men in power positions - kings, church leaders, legislators and medical practitioners. Women were not consulted. Even when abortion was partially legalised, it was still the medical practitioner who had the final say if an abortion could or could not be done (Watkins et al 1992:59). It was this realisation that urged me to have a closer look at the discourses accompanying views on abortion.

## **4. Discourse**

Derrida argues that discourses change as the concepts and language that constitute them change. He states that in language there are no fixed concepts (signified) or sound/written images (signifiers), but that these images are subject to constant deferral and are in relationship with other signifiers Derrida (quoted in Koehne & Warnambool: 2001).

### **4.1 Descriptions of discourse**

Hare-Mustin (1994:19) describes a discourse as "a system of statements, practices, and institutional structures that share common values." As such discourses sustain particular worldviews: "The ways most people hold, talk about, and act on common, shared viewpoints are part of and sustain the prevailing discourses" (Hare-Mustin 1994:20). Madigan and Law (quoted in Freedman and Combs 1996:43) add that "discourse can be viewed to reflect a prevailing structure of social and power relationships."

It is only when one is personally touched by the effects of a discourse that one realises the previous invisibility of the discourse. "Both my boyfriend and I went on an anti-abortion march in London. I dislike

abortions but when it happens to you, you can understand why people have abortions. You come up against all the problems" (Allen 1985:201).

Discourses shape people's choices about what life events could be storied and how they should be storied. They shape people's lives and relationships and are almost always situated in cultural and historical contexts. This is not only true for the therapist but also for the clients who enter consultations. Gee (in Zuber-Skerritt 1996:171) explains discourses as follows:

Discourses are ways of behaving, interacting, valuing, thinking, believing, speaking, and often reading and writing that are accepted as instantiations of particular roles by *specific groups of people*, whether families of a certain sort, lawyers of a certain sort, bikers of a certain sort, business people of a certain sort, churches of a certain sort, and so on through a very long list.

The above-mentioned quote confirms that discourses are created through an expectancy by certain groupings in society as how things in life ought to be, for example in the abortion debate certain groupings consider abortion a sin whilst other groupings considered it an acceptable choice.

## **4.2 Abortion discourse**

When issues of abortion arise, the debate usually evolves around issues such as the right of the foetus, when does life start and is abortion to be considered a sin or murder. Seldom any questions are asked about the position, circumstances or rights of the mother.

The crux of the abortion debate is not whether it is murder or when life begins, but rather the political question: "Who controls the woman's body?" Thus the person who thinks he has the right to control the body of the woman makes the decision over what may or may not happen to the woman's body. "Big campaigns for a pregnant woman's right to choose for herself whether she needs an abortion or not led to the legalization of abortion in many countries of Europe and North America during the 70s – although it is usually the doctor not the woman who has the final right to decide (Watkins et al 1992:59). "Thus ethics of abortion can be understood as a philosophical distraction from the political struggle over who gets to make reproductive decisions for woman" (Halperin 1995:31). The focus shifts from matters of truth to matters of power.

### **4.2.1 Discourses influencing abortion**

#### **4.2.1.1 Male and medical power**

Historically women were excluded from the medical profession though it was women who searched for edible vegetables and roots and in doing so turned themselves into specialists on plants and the properties

of herbs. Trainor (1992:46) states that it was actually women who were the first medicine women. Men were the hunters and women became the foragers, the botanists and the pharmacologists. Ironically, the acquisition of this knowledge lead to women being accused of witchcraft. "Witch means 'wise one'; the activities of witches in ancient times were far from destructive. They were priestesses, poets, healers, diviners and midwives. Witchcraft is the last remnant of women's strength and power and is the craft of the wise" (Isherwood & McEwan 1993:128).

Midwifery was one of the skills "owned" by women that was taken away by men, specifically through developments in the medical profession. "In the process of medicalisation, men, by virtue of their location in the public sphere and their control over science, came to colonise the birth room" (Papps & Olsen 1993:8). Midwifery was a skill practiced by women and as from the sixteenth century, it was combined with the necessary training and skills. In 1904 the Midwives Act was promulgated in New Zealand. Midwives had to register to practice midwifery and midwifery was placed under the control of the Inspector-General for Hospitals in the Department of Health. This left midwives with less and less power in the face of the male dominated medical profession (Papps & Olsen 1993).

During the period 1969 to 1973 an illegal feminist abortion clinic in Chicago was run entirely by women without formal medical training. Before they were shut down in 1973, thousands of safe abortions were done – the only death was of a woman who went to the clinic with an incomplete, badly infected abortion (Trainor 1988:48). The closing down of the clinic reflects how abortion was brought under the control of the male dominated medical profession.

The extraordinary situation has developed where the people who have accumulated knowledge and 'expertise' on women's bodies, from *menstruation* to *menopause* are *men*. However, these power relations between women and men are concealed because the control always takes the form of technical medical issues.... These power relations do not just come from patriarchy, but also from the capitalist organisation in society.

(Trainor 1988:50)

#### **4.2.1.2 Gender distribution in medical practice**

Gender stratified statistics clearly indicate a disparity between medical practitioners. I use statistics provided by the South African Medical and Dental Society on 30 July 2000:

**Table 1:** Distribution of gender in medical practice

<b>Gender</b>	<b>Total</b>
Male	22 2726
Female	7387
<b>Total</b>	<b>23 0113</b>

Statistics do not provide gender information regarding gynaecologists and obstetricians.

Taking into consideration that it is women who undergo abortions and that there is 96% more male than female medical practitioners also accentuates the discourses gender and power.

#### **4.2.1.3 Socio-religious attitudes**

Whenever abortion is discussed, ethical questions are asked: "When does life begin?", "Is abortion murder?", "Who has the power to choose over life and death?" Many denominations claim that abortion is a sinful practice. It was in 1896 that the Roman Catholic Church officially announced abortion as sin. (Trainor 1988:48). Though this ruling was made over a century ago, this view is still being held – not only by the Roman Catholic Church but by many other denominations as well.

It is in this context that we need to respond to the challenge made by Rossouw (1993:903) to move from "being right" to "doing right". This implies that the consequences of rules made by the church should be deconstructed by exploring the effects of these rules and regulations on the people the rules and regulations apply to. The question needs to be asked: "What is the effect of saying that abortion is murder on the woman who has no other choice?" Rossouw (1993:903) suggests an answer to a similar question: "Christians of all kinds should therefore not only be sensitive to suffering in general, but should be especially sensitive to the practical consequences that theological perspectives and belief practices might have."

Vogelsang (1992:11) made me realise that we are all individuals with different realities that influence our decisions and behaviour:

We stop heated interchange to ask each other about our positions and understandings. Where does the belief that abortion is murder or that pro-choice is correct come from? Who is fostering those stances and how do they benefit from fostering those stances? Who seeks out abortions at the local clinic? What do we know or speculate about what influences their decision to have an abortion? What is our personal struggling with this topic? How do our socio-economic status, our racial-ethnic background and our religious training influence how we interpret this situation?

#### **4.2.1.4 HIV-Aids**

Another ethical dilemma concerns pregnant women who are HIV-positive – may they abort? Although it is no given fact that the child would be born HIV-positive, the baby may eventually end up an orphan or being raised by his or her family or grandparents.

Pro-life activists holds the opinion that "there are no reason for performing an abortion for eugenics concerns, no matter what the suspected 'malady' is, for example, autism, down's syndrome, sex, sexual orientation, poverty or aids" (Chapman 2001).

The Aids and abortion debate have become political. An example is the Bush administration that restricted money for international family planning. According to Booker (2001) Bush's decision will only increase unsafe abortion procedures and the spread of Aids in poor countries as this money was allocated primarily to poor, African countries.

#### **4.2.1.5 Religion and power**

The combination of religion and power resembles features similar to medical power. Based on the authoritative standing of the church in society, the church has always been in a position to pass rules and regulations on abortion, influencing the way people think and act.

Archbishop Desmond Tutu (Govender 1998) believes that women have the right to choose whether they want an abortion. This remark is an indication that not all clerics (or men for that matter) share the standard perception of abortion. Tutu's remark comes as a strong support for women's rights as he is a prominent and revered church leader and member of society. His position as chairperson of the Truth and Reconciliation Commission and Archbishop of the Anglican Church in South Africa contributed to the strategic value of this remark. In elucidating the position of the Anglican Church, Tutu said: "Abortion may be the lesser of two evils. You cannot be absolutist about it and say it must never take place" (Govender 1998).

There is still much controversy about the acceptance of abortion in society. "Pregnant women need practical and emotional support – not moralizing – when they decide they want to terminate a pregnancy or carry on with it. All too often, it is a decision that has to be taken in secret, and its cost borne by the woman" (Watkins, et al 1992:59).

#### **4.2.1.6 Racism**

In South Africa racism has always been and still is a relevant issue. Visiting director of sixty-six African-American pro-life groups in the United States, Johnny Hunter (*Is abortion... 1999*) remarked: "It is disturbing that abortion advertising is far more prevalent in black townships than in other parts of South African cities." In the article *Is abortion another form of racism?* (*Is abortion... 1999*) Hunter argues that abortionists take advantage of poverty and unemployment to ply their trade implying that abortionists can contribute to population control of black people by means of abortion.

However, on the other hand, the above-mentioned remark made me wonder if women in black townships were not made aware of abortion, whether this was not a way of discriminating against them? Keeping them poor and out of the economic sector and keeping them from facilities available to them?

By 1984 the colour ratio in South Africa was one white person for every seven black person. The South African state at that time attempted to deal with the "imbalance" by prescribing to black women Depo-Provera or by performing sterilisations without prior consent just after childbirth (Trainor 1988:53). One of the side effects of Depo-Provera was infertility and the ethics of this practice was questionable and widely questioned. The political question that arose: "Who has the right to make a decision on the continuing existence of a race?" Especially by a group of people who never were a minority, and knew what the effects of such treatments were.

#### **4.2.1.7 Legislation: Practice, rules and regulations**

A woman under the age of twenty-one needs the consent of her parents to get married. However, the Choice on Termination of Pregnancy Act, No. 92 of 1996, states:

In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated. Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

The above-mentioned quote reflects one of the discrepancies regarding parental consent confirms that South Africa has one of the most liberal abortion laws in the world (Althaus 2000). Not only are legal terminations available on request during the first 12 weeks of pregnancy, but also no parental or spousal consent is required for minors or married women. From a pro-choice perspective the woman has a choice where it concerns her body. Getting married is about a legally binding contract between two people. The discourse above would thus make sense according to the pro-choice stance and values because the woman can decide on abortion where it concerns her body. From a pro-life perspective the value of life is

more important than a contract. It could be a point of serious contention for the pro-life counsellors should one value a contract more important than a life.

As counselling is being done by means of language, the counsellor becomes the conversational artist to co-construct alternative stories in the client's life. The counsellor thus needs to be aware of what the effect is of the language used during counselling and need to be aware that language constitutes meaning. This will be introduced in the following paragraphs.

#### **4.2.1.8 Language as medium discourse**

The importance of language in the abortion discourse becomes evident in the following remarks. Joseph M. Scheidler, an anti-abortionist campaigner, in his attempt to prevent couples to go through with abortion, said: "Deciding an abortion together is plotting the death of one's child together and is a despicable evil." William R. Baird, the "father of abortion rights" said, "he feels the decision is the woman's, not the state's or mine ... I am not pro-abortion, I am pro choice" (Shoshtak et al 1984:166).

Shoshtak et al (1984:147) state that men are more open to be part of the counselling process when the counsellor does not use the word "therapy" or "counselling" but rather terms like "explaining the procedures". Perhaps it is because men are trapped in the discourses that therapy is for women and that society expect of them to be in control. Another question that comes to mind is if they (men) experience counselling as a form of reprimandment and are they constituted in the counselling process as the "guilty party"?

Another indication of how language can constitute a particular meaning in the abortion discourse is the use of the terms "foetus" and "baby". Pro-Life counsellors prefer "baby" indicating the status of the unborn child as a human being. Pro-Choice counsellors use the term "foetus" during counselling and when they explain the abortion procedure to their client they refer to the substance that is removed from the uterus as the "product". By using these terms, no value is attached and no judgement is passed.

#### **4.2.1.9 Capitalism**

In a capitalist society many of the day to day human behaviour is driven by supply and demand of goods and services and the monetary value attached to a service. Skilled resources such as medical practitioners and counsellors would present their services to institutions on the basis of the salary they can earn from their services. In the same way contraception is seen a product that is offered to the community at a price for the supplier to earn profit.

Capitalism is not only about the profit motif, but also embrace other values in certain situations. For example during 1953, contraception was made available in the United States to a married woman only if she could prove that she was married and was prepared to have children before contraception could be issued (Trianor 1988:51).

In contradiction to the above paragraph a more serious value issue in terms of health risks seems to have been deliberately overlooked. Some contraception methods had negative side effects – loss of libido, infertility and suppression of orgasm. A question coming to mind is whether men would be willing to take contraception with the risk of suffering the mentioned side effects? Another example is RU-486 drug. The RU-486 drug, known as the "abortion pill", is as much a blessing as contributing to the financial gain for pharmaceutical companies. The RU-486 drug is manufactured by a Chinese firm and is sold in the United States and Europe (Chinese firm 2000). It is described as a safe alternative to surgical abortion (Mariestopes uk 2001). The RU-486 drug is sold at £350 at Pro-Choice Clinics in the United Kingdom. Critics are of the opinion that the RU-486-drug is a threat to women's health. This emergency contraceptive has proven a big hit by Thai-males as some use it as an alternative to condoms (Barnes 1999). The use of the RU-486 drug does not only increases the risk of aids, but a woman who uses it regularly tends to develop internal cysts. The RU-486 drug is freely available at a market related price regardless the consequences thereof.

Pro-Choice Clinics in the capitalist environment also reflect certain important discourses. In the following paragraphs the practical situation is described where the non-profit driven pro-choice clinics in first world countries earn a positive income. They utilise this income for funding skilled resources and then to utilise the remainder of their funds to render services in third world countries that cannot afford to pay for their own professional services.

Services rendered by pro-choice clinics in the United Kingdom rate from £50 for the initial consultation to £625 for an abortion during later phases of gestation (between fourteen and nineteen weeks). The statistics of the United Kingdom is an example of this discourse. During 1996, 177 225 abortions were carried out in England and Wales – "...9 577 of those women came from overseas, or from elsewhere in the British Isles, such as the Irish Republic, or Northern Ireland, where abortion is illegal" (Resources 2001). These statistics confirm that 87% of these abortions were carried out before the twelfth week of pregnancy. Such an abortion costs £325. The amount for these abortions rendered adds up to £50 110 368. The conclusion one comes to, is that abortion could be a profitable business. However, this particular Pro-Choice Clinic whose mission it is to ensure the individual's fundamental human right to have children by choice and not chance, empowers women throughout the world regarding their own fertility and reproduction. They provide

family planning services to less fortunate countries subsidised by profits they earn from first world countries. Other projects this organisation is running are awareness campaigns amongst adolescents in Kenya, encouraging men to take responsibility for contraception in Malawi and taking reproductive health services to the workplace in Bangladesh (Press Centre 2001).

This pro-choice organisation also uses modern marketing techniques to promote both condoms and femidoms. In campaigning family planning in Uganda, Ugandan bicycle sales-men are now selling condoms and in India, rickshaw drivers do the selling of condoms. Regarding refugees, this pro-choice organisation has put programmes in Africa, Asia and Latin America in place to serve displaced communities, whereof eighty percent are women and children (Press Centre 2001). The discourse discussed here reflects on the ethics to use the profit from one country in a capitalist environment to render services at a loss in another country. In a capitalist country where abortion is not legalised the individuals with enough money available could go to capitalist countries where abortion is legalised and buy the services they require. Individuals from the same country, (abortion illegal) who do not have enough money to afford the services they require, have a dilemma. They do not have access to free services similar to the services rendered to third world countries free of charge and they cannot go to countries where it is legalised.

In South Africa, part of the backlash is the restrictive availability of contraceptives and abortion services due to accessibility and fees involved (Althaus 2000). South Africa is a blend of first world and third world realities. Abortion has been legalised and the availability of abortion services are between free services in state hospitals and expensive services at private clinics. Between these extremes we find the pro-choice clinics that render services at nominal tariffs. The first world portion of the community has transport and resources available for any of the mentioned services. Remote rural communities, classified as a third world environment, do not have transport or resources available to utilise any of the abortion services. It is said that Pro-Choice organisations, though they render an abortion service, place a restriction on services (Althaus 2000). Pro-Life Clinics renders free services. Regardless the free services of Pro-Life Clinics or the services at nominal rates from Pro-Choice, the services could not be fully utilised by portions of the community who stays in remote rural areas.

In the capitalist situation of South Africa there is not a social security fund available to the unemployed. Should abortion services not be available to the single female, it will lead to a single parent situation where the single parent has no source of income while attending to the newly born baby. The discourse here is that the capitalist system makes provision for terminating the pregnancy but not caring for the single parent or newly born baby after birth.

From the paragraphs above, reflecting on the capitalist discourse, it is interesting to observe that the capitalist environment generates profits from women facing unplanned and unwanted pregnancies and at the same time provides free services to those in need based on morals and other values. Due to the geographical and socio-economic situation in South Africa, not all needs are provided for regardless of the fact that free services are available or funds are allocated. The capitalist discourse contributes to the fact that contraception is not available to all women and thus contributes to abortion. Where abortion is not legal or available to women, it contributes to back-street abortions or the woman has to continue with the pregnancy, again facing different alternatives from adoption to foster care to single parenting.

The discourses discussed above need to be deconstructed to reflect on the affect thereof on the woman facing an unwanted or unplanned pregnancy.

## **5. Deconstruction**

### **5.1 Definition of deconstruction**

No definite definition of deconstruction exists because this would mean that the definition would again “set” deconstruction in a modernist way with definite implications and meanings. White (1991:21) says the following about deconstruction:

[D]econstruction has to do with procedures that subvert taken-for-granted-realities and practices; those so called ‘truths’ that are split off from the condition and context of their production, those disembodied ways of speaking that hide their biases and prejudices, and those familiar practices of self and of relationship that are subjugating persons’ lives. Many of the methods of deconstruction render strange these familiar and everyday taken-for-granted realities and practices by objectifying them. In this sense, the methods of deconstruction are methods that ‘exoticize’ the domestic.

During the research process, I was interested in discovering, acknowledging and taking apart and undo, but not destroy (Sampson 1989:7) the beliefs, ideas and practices of the culture in which we live. By doing this, the cultural beliefs that have assisted the problem to come into the person’s life and the beliefs and ideas that are assisting in sustaining the life of the problem, become more available for questioning and challenge. The beliefs and ideas that are assisting problems are often regarded as “taken for granted” as “truths” or as “common-place understandings”.

Some dominant discourses in our society are those of race, gender, class and capitalism. All of the mentioned discourses have been and still is present in our society. With reference to abortion, the dominant discourse is: “Who has the power to decide over the body of the woman.” In order to deconstruct this

dominant discourse in society and during counselling the counsellor needs to be accountable for what he or she says (language discourse) or does during the counselling process.

## **6. Reflection**

Reflecting on the history of abortion as well as the social construction thereof, I came to realise that the dominant voices, creating dominant discourses, were not those of women who are affected by an unwanted pregnancy, but the church, males and the medical profession. The church decided abortion is a sin and through this decision moral implications were and still are attached to the abortion debate.

The following remark by Vogelsang (1992:13) suggests what should be done to the discourse issue:

How do we do the right thing in a post modern society? We gather in discourse to put authority and truth at play, to hear the voice of those who have been oppressed, to experience our own anxiety, to be in the presence of the other, to release alternatives, and to go forth convicted and committed to action.

The above-mentioned quote once again brings the research questions to the fore namely:

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

## **Chapter Three**

### **Values and narrative pastoral counselling in abortion counselling**

#### **1. Introduction**

Abortion counselling is a value-laden issue riddled with controversy – a controversy challenging not only the value systems of narrative pastoral counsellors and those of their clients, but also the value systems of the cultural community. The research questions I pose in this study are designed to allow me a closer understanding of how counsellors negotiate values during abortion counselling.

Incorporated in value systems are the issues of accountability and ethics, interwoven with the power position counsellors find themselves in during abortion counselling. This power position relates very closely to the ethical responsibility counsellors face, should their value system differ from those of their clients.

In this chapter, narrative pastoral counselling is defined and discussed in the context of values, value systems and ethics. Relevant practical situations are discussed to consolidate the position of both the counsellor and the client.

#### **2. Narrative pastoral counselling**

##### **2.1 Description of narrative pastoral counselling**

Narrative counselling can be described as:

Narrative therapy seeks to be a respectful, non-blaming approach to counselling and community work, which centres people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.

(Morgan 2000:2)

The term "pastoral" as used in pastoral counselling, refers to the description of "spirituality" in Kotzé and Kotzé (2001:1) where "spirituality" is referred to as being "more inclusive, focusing on any of our experiences including theological ideas and narratives about the Other whom some call Friend/God/Goddess, Divine and so forth."

## 2.2 Narrative pastoral counselling

One of the aims of narrative pastoral counselling is to co-construct alternative stories with the client – “not just any alternative stories, but stories that are identified by the person seeking counselling as stories by which they would like to live their lives” (Morgan 2000:14). In the case of abortion counselling the counsellor would have the opportunity to co-construct an alternative story with the client regarding the unwanted pregnancy as well as decisions regarding the termination of the pregnancy. Together with the expert local knowledge of the client (Anderson & Goolishian 1992), the counsellor becomes the conversational artist in exploring and co-constructing alternative stories with the client.

The “not knowing” position of the counsellor is derived from the fact that the client has the expert and local knowledge of his or her own life. Anderson and Goolishian (1992:28) regard therapy or counselling as a process in which “we are always moving toward what is *not yet known*.” This implies not asking questions from a position of pre-understanding and not asking questions to which we want *particular* answers (Friedman & Coombs 1996:44). The “not yet said” is thus not yet known by the counsellor nor by the client.

In abortion counselling a “not knowing” position implies that the counsellor is curious as to what the effects of the unwanted pregnancy are on the client's life, what alternatives she has in her current situation as well as her decision for the present or the future.

In the narrative pastoral counselling process the client as the expert and the accountability of the counsellor are two cardinal aspects. These aspects are discussed in the following paragraphs.

## 2.3 The client is the expert

When the counsellor as conversational artist works from a position of “not knowing”, he or she becomes the co-author of the client's alternative stories. Through this conversation co-construction and re-authoring of life stories take place. Though the client is seen as the expert regarding his or her own decision-making, the counsellor has the professional knowledge regarding the counselling process. The counsellor is “not knowing” in order to remain open to search for the “not yet said” (Anderson & Goolishian 1992).

[A] not knowing-position is not an ‘I don't know anything’ position. Our knowledge is of the process of therapy, not the content and meaning of people's lives. We hope that therapy is a process in which people experience choice rather than ‘settled certainties’.

(Friedman & Coombs 1996:44)

According to Anderson and Goolishian (1992:28) a “not knowing” position that values the client as the expert of his or her own vivid experiences “requires that our understandings, explanations, and

interpretations in therapy not be limited by prior experiences or theoretically formed truths, and knowledge." However important these "prior experiences or theoretically formed truths", the emphasis in narrative pastoral counselling is on remaining open to search for the "not yet said."

By listening to people's stories in order to gain some understanding of their local culture and particular dilemmas, the counsellor becomes part of their experience of the world. Freedman and Combs (1996:277) argue "this initial listening sets an ethical tone in which we commit to joining people in their struggles (provided they are open to that kind of relationship)."

Due to the fact that the counsellor's professional knowledge ascribes to him or her a power position, it leaves the counsellor with the responsibility towards the client not to misuse this power. In an abortion counselling situation with the client valuing the opinion of the counsellor, the counsellor should be aware not to misuse his or her power to influence the client in favour of his or her (the counsellor's) value system.

[W]e are part of the dominant power/knowledge domain. We cannot be completely outside of dominant practices, but we can take responsibility for working to see through dominant cultural stories. This requires that we deconstruct our practices and situate our ideas in our experience.

(Freedman & Combs 1996:117)

Due to the fact that counselling takes place through language and that meanings are constituted in language, the counsellor is accountable towards the client both for what is said and done as well as what is not said and not done during the counselling process. I came across an example of the "not said and not done" during my interview with Pro-Life counsellors. They confirmed that they would never refer a client to an abortion clinic even if the client's choice were for the termination of the pregnancy. The reason for this is that these counsellors feel so strong about the "wrongness" of abortion and that it clashes with their value systems in such a way that they refrain from referring a client to an abortion clinic.

Whether the counsellor is working from a pro-life or a pro-choice stance, counselling ethics emphasise accountability towards the client.

#### **2.4 Accountability towards the client**

Accountability on the side of the counsellor can be reached through the following:

## **2.4.1 Transparency**

Ensuring an atmosphere of curiosity, respect and transparency is the responsibility of the therapist.

(Morgan 2000:130)

Transparency can be seen as being open about *why* one is saying *what* one is saying. Against the background of transparency being the “responsibility of the therapist” or counsellor, Freedman and Combs (1996:276-277) emphasise the therapeutic value of transparency:

Therapeutic curiosity that directs itself only to narrative accounts of client restraints, without publicising and recognising counsellor restraints, continues to perpetuate modern myths of expert knowledge. Although not everyone is interested in contributing to these conversations inviting counsellor transparency, those who are interested usually find this process extremely meaningful.

Transparency ought to be a way of being for the counsellor – a way of being with no place for hidden agendas to influence the client to the counsellor’s own belief system.

## **2.4.2 Self-reflection**

The process of reflecting is post-modern ethics in action. If we as counsellors argue that we are willing to be accountable for the effects of the counselling that we facilitate, then we need to be self-reflective regarding the effects our questions may have on clients. If counsellors believe in the ideas that they are sharing with clients, they are accountable to the clients for the effects of what is shared. The issues we as counsellors can reflect on are the effects that our current beliefs and behaviours have on the lives and relationships of the people who consult us. Moreover, as counsellors we need to reflect on the influence our beliefs and behaviours have on our local culture.

Counsellors can also reflect on the effect clients have on the counsellors’ own lives and how these effects shape our lives. Reflection on our own continuing development as counsellors can also be valuable – not only for our own personal development but also for professional and therapeutic development.

Self-reflecting highlights the values of the counsellor. Clients have their own values and so do counsellors. Questions asked by counsellors are shaped by their own values, but these questions also shape the stories about people and counselling. Attention should therefore be given to the role of values inherent in the questions being asked in the counselling process.

In the next paragraphs values, value free counselling, value systems, religion and value systems as well as pastoral care and value systems will be discussed.

### **3. Values**

Since we are interpretive beings, values are foundational to our reality and therefore an inseparable part from the counselling process. Not only are values an inseparable part of our existence; values also function as the lens through which we view reality. However, values become "invisible" (as is the case with a lens) – one hardly knows that they are there. Rokeach (1973:5) defines a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence." For example, value clashes are fundamental when two or more individuals reach different conclusions regarding the facts, logic, and/or the organisational structure of information regarding their worldviews (Mitchell 1993:204). Fundamental value clashes are common around contentious social issues such as abortion, racism, sexual orientation, open marriage, gender inequality, euthanasia, to mention but a few. Again the research questions come to the fore:

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

#### **3.1 Value-free counselling?**

The notion that counsellors could be value-free in counselling is incongruent with a social construction understanding of reality (Paré quoted in Muller 1996:636). Social constructionists argue that a person (a counsellor in this case) cannot dissociate him-/herself from his/her own values – the counsellor's values are influenced by his or her culture and consist of value choices that are ideologically determined. O'Brien (1984:14) comments that counsellors' values are "an integral part of the counselling process and they do influence both the process and outcome.... Values influence goals, techniques and the justifying of theory; in short they influence everything."

In addition, the client's value system needs to be taken into consideration. During the counselling process new meanings between the client and the counsellor are established and the counsellor's narrative will influence the client and vice versa.

### **3.2 Value systems**

Values influencing our attitudes and behaviour eventually form a value system. According to Rokeach (1973:7) a value system is "an enduring organization of beliefs concerning preferable modes of conduct or end-states of existence along a continuum, of relative importance."

We all have certain values and beliefs that determine who we are. These personal values and beliefs imply that morality is not only a relational issue but is also very personal and has ramifications that are very personal. To bridge this dilemma Kotzé and Kotzé (2001:7) suggests that "A commitment to do pastoral care as participatory ethical care immediately challenges us not to care *for* but *with* people who are in need of care." If counsellors strove to counsel in the latter way, it will have the move away from "a caring response or Christian sense of guilt, away from paternalistic care and undue protection, towards care as a social practice where it is socially constructed by care-givers as well as care receivers."

When we hold certain clearly defined values that are personally significant and then do not act on those values in therapy we may experience a moral dilemma. Melton (1968) described this moral dilemmas 'value schizophrenia.' He uses the word schizophrenia to highlight the splitting of personal values from the values that are expressed in therapy.

(Carlson & Erickson 1999:62)

The abovementioned quote emphasises that the counsellor cannot ignore his or her own value system as it leaves the counsellor with a moral dilemma that should be addressed in one way or another in order not to do counselling and in doing so to become cynical, fundamentalist or suffer from burn-out.

In the case of a value conflict between the values of the counsellor and the client, it is recommended that the counsellor rather refer the client to another counsellor. Mitchell (1993:210) argues "ethical counselling concerning fundamental value clashes aims at minimizing counsellor bias and maximizing counsellor integrity in order to ultimately maximize respect for clients."

Religion forms many of our human values and value systems. Religion and value systems are discussed in the next paragraph

### **3.3 Religion and value systems**

Whenever a client seeks counselling from a pastoral counsellor, pastor or minister, the counselling has a religious undercurrent.

According to Muller and Swanepoel (1996:635) there is a divine dimension present in pastoral counselling. It brings to the fore the role that religious values play during the counselling process and that the counsellors unique value system will influence the counselling process in one way or another. This is also true of the client's value system.

A study done by McCullough and Worthington (1995:627) showed that the way in which religion is used in counselling has an effect on the outcome of the counselling. This study also indicated that a client whose religious values co-incided with those of the counsellor evaluated the counsellor positively, but where the counsellor challenged the client's religious values, the counsellor was evaluated negatively (McCullough & Worthington 1995:633).

Though the abortion counsellor needs to be ethical, respectful, sincere and gentle during counselling, it should be taken into consideration that, during the counselling process, situations could arise where the effects of the client's value system could be harmful to others. In the latter case it would be a prophetic challenge to the counsellor to create an opportunity for transformation and change in the client's life. This "transformation" is established within the context of a therapeutic conversation. Even though I refer to a "prophetic challenge", the idea is never to impose an opportunity for transformation or change on the client. The same rules apply as described earlier in this chapter – those of the client being the expert and the counsellor being curious and "not-knowing." Pastoral counselling from a narrative approach focuses on the exploration of *preferred* alternatives – preferred in the sense of "creative transformation" that would lead to the benefit of all involved. Gerkin (1991:14) describes this process: "The opportunity is that, in a situation of norms and values flux, some of the reified values and oppressively constricting boundaries that have brought harm to some members of the society may be broken open and become subject to creative transformation."

Research (Muller & Swanepoel 1996:640) shows that counsellors, in spite of their own beliefs and convictions, do respect and accept clients' values – even if clients' values differ from their own. In doing so, these counsellors do not force their own opinions and values upon the client. The perception is commonly held that pastoral counsellors working from an evangelical approach would have even more tolerance and respect towards the values of their clients as well as other people.

Research show that it appears that the counsellor can easily direct the client in a specific way The mentioned researched finding leads to the preference that counselling within a social constructionist approach would add new meaning to what is happening between the client and the counsellor. (Muller & Swanepoel 1996:637).

The above-mentioned view urges the counsellor to be open and honest about his or her preconceptions and distrusts towards other people's cultures. Pastors and counsellors ought to know and be sensitive to the fact that their value systems will in one way or another have an influence on the counselling process. (Muller & Swanepoel 1996:640-641):

The impossibility of therapeutic 'objectivity' calls for acknowledgement of norms and for recognition that a specific counsellor might not be capable of being therapeutically involved in specific circumstances due to conflicting value systems.

Abortion counselling leaves ample room for influencing the client in a specific way. Apart from the role societal discourses on abortion and moral obligations are playing, the pastoral counsellor could influence the client either for or against abortion. I would argue that a post-structuralist approach to counselling could save both client and counsellor from this.

The pastoral counsellor needs to find a balance between his or her own value system, the value system of the client and be able to counsel and stay true to his or her own beliefs and values.

### **3.4 Pastoral care and value systems**

Pastoral counsellors need to be alert to how their own value systems are playing into the care and counselling process. With reference to pastoral *counselling* Neuger (1995:139) states:

No matter what our position is on the rights and responsibilities of abortion, it is impossible for us to be disinterested in the process by which people reflect on their pregnancy decisions. At some level, we are always asking ourselves about the meaning and value of our lives and at what stage that value emerged. In the abortion debate, lives are on the line, symbolically and really. [We] need to gear our efforts toward helping our counselees engage in ethical reflection to the end of making their own faithful and healthy choices.

With reference to pastoral care, Woodruff (1990:227) remarks that when the value system of the pastor differs from that of the client, the pastor needn't give up his or her own value system. It also doesn't imply that whatever other people are doing would be acceptable. It means that one ought to have unconditional positive regard, care and appreciation for other people without seeing them as a bundle of behavioural problems. In theological terms, "grace in human relations" (Woodruff 1990:227).

Woodruff (in Neugar 1995:135-136) also states that counselling is a *person-centred* opposed to an *issue-centred* arrangement. In his reflection on abortion and pastoral counselling Woodruff further states that

being person-centred is positive in the sense that the pastoral counsellor is willing to see the concrete contexts of any situation and is willing to understand the life of the person in need. He further states:

Pastoral counsellors have also been willing to be 'open to the larger conversation' and to join perspectives with counselees in the effort to help people broaden the parameters of their own conversation. They have suspended judgment so that the counselee can strengthen and move toward her or his own capacities for moral reasoning and make decisions that can be owned. He confirms that abortion requires the largest possible lens through which the concrete particularities of each individual crisis should be appreciated.

Steward and Gale (1994:18) offer another perspective:

Most potential consumers of psychotherapy services would prefer not to have a 'value free' counsellor. In a 1992 Gallup Poll, 66% of respondents state that, when confronted with the need for counselling, they would prefer a therapist who represented spiritual values and beliefs. Moreover, 81% would prefer a therapist who enables them to integrate their [clients] values and belief system into the counselling process.

Both quotations, by Woodruff as well as by Steward and Gale, imply that the pastoral counsellor needs to be very sensitive in his or her attitude towards the client to reconstruct and to co-construct the alternative story of the client.

### **3.5 Doing right versus being right**

The counsellor's personal experiences, opinion about abortion and religious background and values should not influence the counselling process. "It is not about being right but doing right" (Rossouw 1993:903). The client is the most important person in the counselling process and the goal is to facilitate optimal functioning true to the client's own self. I use "optimal functioning" to indicate the client's preferred way of being or doing. This is where the ethical responsibility of the pastoral counsellor lies, within the consequences of theological paradigms and theological understanding of the world. Hart and Nielsen (quoted in Rossouw 1993:228) make a valid comment on the "Christian" characteristic of ethical responsibility: "Theologies and Christian practices that cause systematic or prolonged suffering and degradation can hardly be worthy of the name 'Christian'."

## **4. Ethics**

Abortion crystallizes crucial issues for pastoral theology and pastoral care and counselling – the meaning of value of life, way to understand family, the role and value of women and men, the cultural and personal splits between production and reproduction, and the meaning of spiritual discernment and ethical reflection in pastoral counselling.

(Neuger 1995:125)

The "crucial issues" Neuger (1995:125) refers to, are indication of the pastoral counsellor's ethical responsibility towards the client.

The shift from modernism to post-modernism has affected the way we discuss and choose "the right thing to do." "For postmodernism there is no longer an absolute authority upon which to base ethical choices, or a 'meta-narrative' of universal principles and rules that can explain and govern actions" (Vogelsang 1992:5). When we think about ethical discourse we need to ask what is influencing how we see, think, and feel. How does being part of a dominant group or subordinate group shape what we call right and wrong and exclude alternative considerations? When we think "white" or "male" do we have more choices than when we think "black" or "female"?

To be ethical during the counselling process implies that the counsellor must be aware of the effect of what he or she is saying has on the client. It could have a devastating effect on a woman with an unwanted pregnancy seeking an abortion, if the counsellor should tell (inform) her that in his or her value system abortion is regarded as murder and as sin. This kind of information would be imposing the counsellor's value system onto the client.

Another important area of inquiry is *also asking about effects*. We regularly ask about the effects of particular interviews and of the therapy process as a whole. The answers to these questions help us revise our work so that it fits different people in different situations. Tailoring therapy in response to people's preferred effects demonstrates our accountability for the effects of our words.

(Freedman & Combs 1996:281)

The accountability of the counsellor is taken further in Kretzschmar's (1998:3) remark – that the counsellor should ask him- or herself the question, what are the consequences?

Theological ethics ... is concerned with identifying norms of right or wrong and seeking to determine what constitutes good (or bad) motives, goals and consequences. The ethicists want to ask whether customary behaviour is right. The ethicists also want to ask whether the goals, consequences and motives of certain forms of behaviour can be considered to be good or beneficial.

(Kretzschmar 1998:3)

Working from a position of "not knowing" and "the client is the expert" as discussed in paragraph 2.2, has consequences for pastoral ethics. True to the epistemology that every person has his or her own construction of reality, each person can find an own solution for her or his problems – keeping in mind that the problem is the problem and the person is not the problem. Because there is no absolute truth, the

pastoral counsellor cannot force the client to support his or her (the counsellor's) values. Therefore, if the client feels that an abortion is her solution to the problem it would not be ethical for the pastoral counsellor to direct the client in any other way. This confirms again the pastoral counsellors accountability during the counselling process.

In narrative pastoral counselling the challenge of the "not knowing" position lies within the questions asked by the counsellor. Questions to reclaim undeveloped knowledge in order to co-construct the alternative story with the client. By asking questions from a "not knowing" position, the counsellor co-constructs alternative stories with the client. By allowing the client to reflect on the dominant as well as the alternative stories the counsellor stays accountable, not imposing own values on the client. The following quote by Loewenberg and Dolgoff (1996:23) confirms the above-mentioned paragraph:

Both societal and professional ethics stress the principle of equality, but professional ethics give priority to the client's interest ahead of the interest of all others.

#### **5. Discussion of some issues situations faced by the narrative pastoral counsellor during abortion counselling**

Abortion involves complexities such as historical, political, legal, philosophical, clinical, theological, racial, class and gender dynamics. The complexities as mentioned, and the principles of narrative pastoral counselling, values and ethics, results in the handling of certain day-to-day situations. These situations are being discussed by formulating different questions and by reflecting on these questions from a narrative pastoral perspective.

**Question:** *Who is affected most by the abortion decision?*

**Reflection:** An important issue raised by Neugar (1995:139) is that those people who benefit the most from the values of the dominant system must learn to listen to those who are most marginalised by it. Those who are best able to reveal the injustices of a system are those who have been most harmed by it. Reflecting on the latter sentence, it seems that in South Africa it was woman, and specifically black women that were and still are affected by the religious, racial, class and capitalist discourses of abortion.

**Question:** *Does only objective truth exist?*

**Reflection:** With reference to social construction (Burr 1995) and specifically that no objective truth of only one reality exists, narrative pastoral counsellors will be able to assist the client in co-constructing an alternative stories that fits with the client own truths and realities.

Without understanding and critiquing the oppressive dynamics of racism, classism, and sexism, we will be unable to contribute to the abortion debate in empowering ways.... Since abortion is primarily about women and children, and especially poor and working-class women and children and women of colour, our work in theological and psychological discernment around abortion issues is relatively meaningless until we can see the dynamics of the culture in their appropriate place, and unless we can become person-centered and issue centred.

(Neuger 1995:137)

Neuger once again confirms that abortion is not an isolated issue only concerning the presented issue of an unwanted pregnancy. Though an abortion decision should be a decision made by the individual, this choice is made difficult and influenced by discourses such as culture, race, class, gender and religion, of which the narrative pastoral counsellors should take notice of during the counselling process.

**Question:** *The client's need for immediate as well as ongoing support and counselling?*

**Reflection:** The discourses referred to above stress the fact that it would not be ethical towards the client or in the client's best interest to take a fundamentalist position during abortion counselling. The pastoral counsellor needs to empower the woman in her decision-making by taking into consideration all possible factors and not only a personal opinion or the opinion of society and the church.

Another important issue that the narrative pastoral counsellor should take into consideration is that an unwanted pregnancy involves long-term commitments. When it comes to the decision of either full term pregnancy or abortion, the person who is responsible for the care and support of the child should be able to have the clearest voice in making the decision about reproduction (Neugar 1995). This implies that religious institutions should not misuse their power to decide about the "right" or "wrong" of abortion if they are not fully aware of the circumstances accompanying the unwanted pregnancy. According to a counsellor at a pro-life clinic, it very often happens that a religious institution would offer support to a woman just to prevent her from having an abortion and then the "support" would disappear as she carries the baby full term and is left alone with the responsibilities of raising the child on her own. This scenario confirms the responsibility of narrative pastoral counsellors: "Pastoral counsellors need to be about the business of empowering those voices in a debate which often ignores those who are most concerned" (Neugar 1995:139). This implies that the final decision should be the client's, whose responsibility it is and will become and not the decision of the counsellor, husband, boyfriend, parents, community or church. However, the decision that the woman takes should not be without the full support of the counsellor.

**Question:** *Is neutrality in narrative pastoral counselling possible?*

**Reflection:** The narrative pastoral counsellor cannot have a neutral or isolated stance towards the abortion debate. Abortion does have a spiritual and psychological meaning for the client as well as for the

counsellor. Neugar (1995:139) states that pastoral counsellors need to stay alert to how their own value systems and ambivalences play into the care and counselling process. The narrative pastoral counsellor should stay aware of the way in which people reflect on their decisions.

The pastoral counsellor has a responsibility to be as informed as possible about the psychological and spiritual dynamics of an abortion decision so that the widest possible range of alternatives can be offered to the woman who seeks abortion counselling.

If pastoral counsellors stay alert to the research in the area of crisis pregnancy resolution, they will be able to find the best ways to help people in crisis pregnancies to engage in ethical reflection and decision-making in light of the various complexities of the abortion question. Care during the decision-making process and planned follow-up work, especially with high-risk women, should be considered a standard part of any pastoral counsellor's work with women in crisis pregnancies.

(Neuger 1995:138)

**Question:** *How does faith traditions influence counselling?*

**Reflection:** A difficult matter for the narrative pastoral counsellor as well as for the client is that abortion is closely interwoven with faith traditions. The questions the counsellor as well as the client are left with, are: "What is God's plan for creation, the meaning of free will, the responsibility of good stewardship and the deep existential issues of being, and the purpose of women and men as co-creators with God" (Neugar 1995:139). I would argue that the challenge for the narrative pastoral counsellor lies within the ability to be comfortable enough with the abortion challenges, being able to find ways to invite women who are struggling with unplanned pregnancies into trustworthy pastoral relationships so that the process of exploration and decision-making may enhance their faith lives – introducing an alternative story.

## 6. Reflection

The discussion of narrative pastoral counselling, values and ethics, again accentuates the negotiation abortion counsellors are faced with when it comes to their own values and value systems.

I agree with Vogelsang's (1992:5) perspective that when we think about ethical discourses, we need to ask what it is that influences how we see, think and feel. How does being part of a dominant group or subordinate group shape what we call right and wrong and exclude alternative considerations? When we think "white" or "male", do we have more choices than when we think "black" or "female"? This again confirms that the abortion counsellor always needs to be self-reflective, being aware what has been asked, what has not been asked. Being aware of the effect of what is said to the client regarding an issue as heavily value-laden as abortion.

I view the issues regarding values and ethics as a challenge to the counsellor to develop professionally; not to stay put with grand narratives but to seek new ways and new alternatives to do counselling. This again bring the research question to the fore:

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

It becomes clear that the values and value systems of the counsellors play an integral part during abortion counselling. Everett, Worthington and Scott (1983:323) conclude from their research that counsellors, regardless of setting, responded differently to clients who perceived the importance of religion differently.

Christian counsellors were significantly more concerned than secular counsellors with spiritual issues and viewed spiritual goals as more important (Everett et al 1983:326). Findings suggested that, although both secular and Christian counsellors were sensitive to perceptions of individual clients, the value systems of the counsellors would likely be reflected in the treatment goals they preferred. This confirms why pro-life counsellors would never refer a client to an abortion clinic. The pro-choice counsellors also deem themselves as Christians and their focus is also very much spiritual.

The reflections of this chapter will be explored in more detail in the following chapter with reflection on the interviews conducted with the Pro-Life and Pro-Choice counsellors and the way in which they negotiate their values in abortion counselling.

## Chapter Four

### Reflecting on interviews of Pro-Life counsellors

#### 1. Introduction

In this chapter I present interviews with Pro-Life counsellors and reflect on these interviews. The interviews were conducted from a narrative perspective.

In conceptualising women's behaviour as an expression of social context, as described by Reinharz (1992:53), I use contemporary feminist ethnography as the research methodology. To my mind this requires an understanding of the Pro-Life counsellors' counselling approach as well as their social context.

In the conversations I had with these counsellors, my aim was to focus on my initial research question: What are the value-challenges that abortion counsellors experience? My interest was how abortion counsellors negotiated these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees? Though the goal of the interviews was to obtain answers to my research questions, I was aware that the questions would direct the outcome. The answers to the initial questions would guide me to new lines of questioning. I will discuss these questions later in this chapter.

During my interaction with the Pro-Life counsellors, the following themes emerged: Personal experience and motivation, qualities of a pro-life counsellor, calling and the role of the Holy Spirit, group interaction including group meetings and intercession, sparkling moments, belief and value systems, truth and grace and a non-judgmental attitude.

#### 2. Narrative interviews: questions and reflections

##### 2.1 Personal experience and motivation

The Pro-Life counsellors I interviewed had personal experiences they believed to have been the way in which the Lord prepared them for the work they were doing at the Pro-Life Clinic.

Sandra\*, a post-abortion counsellor, has been with the Pro-Life Clinic for the last two years. Her narrative goes back to her first pregnancy. After experiencing difficulty to conceive, she eventually fell pregnant, only to have a miscarriage during her twelfth week of pregnancy. Though she was devastated and experienced

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\*The counsellors suggested pseudonyms to protect their identity.

this loss as very traumatic, she believed that the miscarriage was part of God's plan to lead her into post-abortion counselling.

Mary-Ann\* started at the Pro-Life Clinic as a voluntary worker doing administrative tasks. Currently she is working as a crisis counsellor at the Pro-Life Clinic. She experienced difficulties in conceiving her second child. Five years after her first child was born, Mary-Ann fell pregnant with her second child. She describes the five years between the pregnancies as a "desert experience" in her relationship with the Lord. She believes this was the Lord's way of preparing her for her work at the Pro-Life Clinic. Mary-Ann enjoys helping people. She sees herself as a "doer" and gets a tremendous amount of satisfaction from watching clients relax during the counselling session.

Nora\* has been working for the past year as a crisis counsellor at the Pro-Life Clinic. She feels that the Lord is leading her into post-abortion counselling. Nora used to live close to the Pro-Life Clinic and every time she passed the clinic, she had an urge to be part of the organisation. It was only after reading *The atonement child* by Francine Rivers, that she experienced the intense calling from the Lord to get involved at the Pro-Life Clinic. Doing crisis counselling at the Pro-Life Clinic gives Nora a feeling of fulfilment

I can understand that these counsellors' personal experiences influenced their involvement in counselling, as it was my own personal experience that made me wonder about negotiating values during abortion counselling. In a similar way as Weingarten (1997:xi), I felt that my research was inspired by "questions that I passionately wanted answers to...."

I lost my first planned baby during birth and another during the tenth week of pregnancy. The pain, loss and emptiness I experienced made me wonder *if* and *how* one could dissociate oneself from such an experience and not influence the client in her decision for abortion during counselling. The issue, drawing on my personal experience, would be that I want to protect the client from the pain of losing a baby. Then again, for the client, keeping the baby (especially an unplanned baby) can cause pain and this is where the negotiation between the counsellor and his or her own values, value system and experiences plays an important role.

According to O'Brien (1984:14) a counsellor can never dissociate him- or herself from his or her own experience or values. This has a definite impact on the counselling as well as the outcome. O'Brien (1984:14) emphasises that "[v]alues influence goals, techniques and the justifying of theory; in short they influence everything."

The Pro-Life counsellors felt not only that they were being prepared for their work at the Pro-Life Clinic through personal circumstances, but that they also had a calling to counsel at the Pro-Life Clinic.

## **2.2 Qualities of a Pro-Life counsellor, calling and the role of the Holy Spirit**

During my conversation with Nora, she used the term “good counsellor”. This urged me to ask her opinion on the qualities of a “good counsellor”. She stated the following qualities:

To be compassionate, to have empathy and sympathy, being able to put yourself in your client's shoes, to be in a strong spiritual relationship with the Lord, knowing that you need the wisdom of the Lord, to love and to have compassion for healing to happen through truth and grace, being non-judgmental, being non-critical even if the client had a third or fourth abortion, humanness, warmth, being able to create a safe environment for your client, being genuine and being 'unshockable' even when you get painful information.

Nora said she thought she always had all these traits but the Lord was constantly strengthening and building these qualities.

To Nora's list of expectations of a “good counsellor” Allen (1985:182) adds sympathy, sensitivity and a non-judgmental attitude towards the client. To my mind the “good counsellor” is a person that has an understanding of the clients' feelings without seeking to impose his or her opinions – ensuring the client's right to self-determination.

Abortion counselling involves advising a woman with an unwanted pregnancy, and informing her on the foreseeable consequences of her decision, without making a decision on her behalf. Accordingly, health personnel working in the field of abortion should be trained to enable women to make a fully informed choice.

I believe that the qualities mentioned by the Pro-Life counsellor are qualities that counsellors in all counselling professions should be able to apply. Counsellors should realise that clients trust them with their vulnerabilities. Bird, (2000:88) working from a narrative perspective, says that she uses the following resources in her counselling:

- An attitude of optimism fuelled by knowledge of people's resilience.
- A belief in relating with respect.
- A positioning of myself as a discoverer and explorer of people's lived experience.
- A confidence that obstacles could be overcome.
- A comfort with conventional therapy wisdom in this area...
- ...dedication to listening for and inquiring around people's strengths and abilities.

Though the counsellors at the Pro-Life Clinic are trained volunteers, they feel that they receive their knowledge, wisdom and “know-how” from the Lord and will never depend on themselves to bring about change in a client’s life, as they are entirely dependent on the Holy Spirit. These counsellors look upon themselves as instruments in the hand of the Lord conveying the compassion and love of the Lord.

The one quality all the counsellors at the Pro-Life Clinic deemed most important, is was being dependent on the Holy Spirit for guidance.

The counsellors I interviewed spoke of an “inner urge”, of a calling from the Lord to do counselling at the Pro-Life Clinic. The Collins Dictionary (1984) describes a calling as “a strong inner urge to follow an occupation.” All three counsellors confirmed that they depended heavily on the Holy Spirit to guide them through a counselling session. They believed that the Holy Spirit facilitated the counselling and sensitised them to the needs of the clients. Believing in the work of the Holy Spirit, they did not always stay with their prepared planning. Mary-Ann’s experience of the guidance of the Holy Spirit was that she would sometimes say something to a client and be astonished about what she said, wondering: “Now where did that come from?”

A specific incident convinced Sandra of her calling. As a rule Sandra did not allow anyone but the client in a counselling session. For some reason she invited a client’s sister to sit in during a session. Sandra felt she was urged by the Holy Spirit to invite the sister to join the session. As it turned out, the client and her sister had unfinished business and the session served as an opportunity for forgiveness.

According to Sandra the Lord confirms from time to time to her that she belongs at the Pro-Life Clinic and that she is where she is supposed to be. A confirmation of her calling came when a mother who had previously undergone a therapeutic abortion due to the diagnosis of Down’s syndrome, fell pregnant again. The mother asked Sandra to pray for her and when the amniocentesis was done, no abnormalities were detected. Sandra experienced this incident not only as a confirmation of her calling but also as an exceptional moment during her counselling career at the Pro-Life Clinic.

Thinking of Sandra’s confirmation-story, I was wondering to what extent a counsellor’s personal story or interpretation of reality should feature in counselling. However, in this session the client requested Sandra to pray for her. Both client and the counsellor’s value systems corresponded. Therefore both were delighted by the results of the amniocentesis.

Should one consider a hypothetical scenario, a possible difference in value systems becomes evident. In the conversation I had with Sandra, she mentioned that the client indicated that she would have considered another abortion were the diagnosis Down's syndrome. Sandra explained to me her own position on abortion. She was adamant that God had a plan with each pregnancy, regardless circumstances or conditions. It came down to abortion being an abortion of God's plan.

I asked Sandra what she would have said were the diagnosis to be Down's syndrome. She only shook her head and said: "I don't know, I don't know what I would have said to God."

### **2.3 Fruit of the Holy Spirit**

During my interaction with the counsellors I came under the impression that they strive to bear the fruit of the Spirit as being described in Galatians 5:21. I came under the impression of their genuine care for their clients and of their firm belief in their values.

Nora said she reminds herself constantly, "What would Jesus do." She thought the stories of the Samaritan woman and the woman caught in adultery, should serve as examples set by Jesus for us to know how to act towards other people.

All three of them confirmed that they regard bearing the fruit of the Spirit (Galatians 5:21) as pure joy. Their shared understanding of calling, of being dependent on the Holy Spirit and of the power of prayer result in a strong feeling of "belonging" between the counsellors.

### **2.4 Strong group cohesion**

The counsellors contribute the group cohesion between them to the love of the Lord binding them together and to the fact that they all have a calling from the Lord. In this calling they share a common purpose, namely to bring about healing in women's lives through truth and grace.

Another unifying factor is their practice of joint prayer and intercession. They would never start a counselling session without praying on their own or with a fellow counsellor. Sometimes, when the pregnancy test of a client is positive, the counsellor would ask her fellow counsellors to intercede for her and for the client when she breaks the news to the client. Even though they rely on praying for each other, for themselves and for their clients, they would never pray for a client if they don't feel lead by the Lord to do so or before asking the client's permission to do so. To me this is showing respect for their clients.

## 2.5 Prayer

Murphy (1996:185) describes prayer in the following way:

It is woven from the texture of our lives and takes many forms: personal and private, shared and vocal, public and liturgical. Prayer can be a cry of gratitude, lament or intercession; it can be an unvoiced longing of the heart, and expression of love and intimacy, or an admission of guilt seeking forgiveness. It can be a childish prayer for 'what we want', a search for security and assurance; or it may be a personal encounter with an 'Other' who is the source of our being and the core of our desires to whom the appropriate response is 'worship'.

Reflecting on the interviews with the Pro-Life counsellors, all of the above-mentioned qualities are encapsulated in their attitude towards prayer.

Although Sandra, Mary-Ann and Nora would only pray with their clients if the clients give permission, prayer has a prominent place in the post-abortion counselling session. One of these sessions consists of the client praying to God to reveal to her the gender of the child and what the child would have looked like had he/she lived (the term *child* is used even if the abortion could have taken place years ago). The client is taken through this procedure to allow her to mourn the loss of her baby and to give her an opportunity to choose an object (for example a precious stone) that could symbolise the tombstone of the child. This session also includes the naming of the baby. According to Sandra, this is the turning point in the life of the client since healing has taken place and the client can move on.

I was wondering about counselling to non-Christian women seeking post-abortion counselling. I raised the question and wanted to know if they thought that post-abortion counselling could be done in any other way than what they were doing. The counsellors replied that they would not know what to do in a session counselling a non-Christian, but that they would rely on the Holy Spirit to guide them. They said that they have not yet been faced with counselling a non-Christian.

According to Shostak et al (1984:293) pre- and post-abortion counselling could be done by providing a sense of social support and shared experience, for example group sessions. During these sessions clients could deal with their fluctuating and conflicting feelings about abortions. Clients could be taught how to recognise and cope with the feeling of loss (that sometimes accompanies abortion) in a constructive way. Shostak et al (1984:295) argue that feelings of loss or grieving do not imply that the client has made the wrong decision. It could be a mere awareness of their loss. Being informed about the stages of grief and mourning, clients would be able to recognise the stages and deal with it, be it individually, in a group session or during a one-to-one counselling session.

My opinion is that group sessions would be difficult because of the stigma still attached to abortion in South Africa. Women are generally reluctant to talk about the fact that they had an abortion. Shostak et al (1984:29) refer to this silence as "the cloak of silence about the subject."

Sandra thought that post-abortion counselling could be done in group sessions, but she felt that the healing these women experienced in group sessions would not be sustainable. She argued that abortion is accompanied by a suicidal tendency that will stay with the woman for the rest of her life if she does not deal with it. According to Sandra, women suffering from post-abortion depression tend to be suicidal. She contributed this to the "spirit of suicide" possessing women after an abortion.

The Pro-Life counsellors work from a rather fundamentalist perspective. I was wondering if they had some ideas on how women seeking abortion counselling would view religion and spirituality. I asked them the following question:

**2.6 Have you developed any idea of how women seeking abortion counselling would view religion and spirituality?**

It should be taken into account that it was the church that first outlawed abortion, defining it as a sin, preaching "culpability", inflating the elements of sin over pardon and forgiveness" (Murphy 1996:90).

Mary-Ann was quite clear about the question. She felt that women seeking abortion counselling did not see religion as a resource at all. If the decision would be in harmony with what the client believed, it would be a different issue. However, she felt that women often had no access to the church as a resource since the church would not endorse their view of abortion. Mary-Ann stressed that she was sensitive for clients' possible negative feelings towards any form of spiritual talk. She would therefore not push anything regarding spirituality or even talk about religion or spirituality during counselling.

Sandra said that some of the clients came from a very legalistic background and believed in severe punishment should they do anything wrong such as an abortion. She said that some women really believed that God would strike them down should they undergo an abortion. Her aim was to provide some "hope" for the client – hope to become herself again and to accept herself without feelings of shame and guilt. Though the latter was Sandra's goal for her client, she would prefer the client to know the "truth" about abortion. She said that she would always wait for the Holy Spirit to provide the right moment to convey "truth" and grace to the client. This remark by Sandra reminded of Isherwood's statement (1996a: 228) that "Feminist theology is questioning the notion of absolute truth and the idea that it can be applied in a standard form to all people."

Sandra was quite convinced that clients could only experience the peace of the Lord after they had a vision of their child during post-abortion counselling. Even though clients do not view religion as a resource at the time of the abortion, Sandra used the opportunity to explain to the clients the "heart of God, the Father", enabling them to understand the unconditional love of God.

Nora was aware of the fact that clients seeking abortion counselling do not always experience religion in a positive way. The way she counteracted a punitive religious attitude towards her clients was by conveying God's humanness and compassion. It was her passion that the client would restore her relationship with God. Her passion extends to convey the love of the Lord to the client. Nora said that she strives to be diplomatic, tactful and respectful. She agreed that she had no right to judge the client or to make the client feel judged. In demonstrating this in a practical way she said she always carefully selects the chair in which to sit during counselling not to sit higher than the client, not to look down on the client. She regarded eye contact as an important contact base with the client.

She claimed that clients are aware of a spiritual aspect to abortion. However, she thought the guilt clients experience, leave them uncomfortable dealing with religious issues and facing God.

In Murphy's (1996:89) reflection on guilt, the theme of patriarchy surfaces. As discussed in chapter two, it was the state, the church and the medical profession, all dominated by men, that approved legalisation against abortion. "Traditional theologies of sin and guilt, grace and salvation, were formulated by white middle class men, in relation to their own experiences, taken to be 'normative'" (Murphy 1996:90). The contributions of "white middle class men, in relation to their own experiences" to feelings of guilt, should not be underestimated. Feelings of guilt, in this context, cannot be separated from patriarchy as a dominant societal discourse.

## **2.7 Guilt**

According to Murphy (1996:90) shame follows when a woman has a persistent feeling that she does not measure up to being the person she is expected to be. Murphy draws a distinction between guilt and shame, explaining that guilt is experienced when we feel guilty for what we have done or have not done and we feel shame for what we are. Following Murphy's distinction, unwanted pregnancy and abortion invite both shame and guilt. Guilt may follow the question: What have I done? Shame may enter with thoughts such as: I am an unwed mother; I am a pregnant teenager; I am a woman who had an abortion. In both cases value systems, possibly informed by institutionalised religion, contribute to feelings of guilt and shame.

According to Nora the guilt and shame a woman experiences could be traced to her own value system. In counselling, Nora would ask the client what her opinion of abortion was prior to the abortion. Nora would make it clear to the client that she is not interested in the opinion of the mother, father, boyfriend or church – she would like to hear from the client *her* opinion of abortion. Usually the client would answer that she was opposed to abortion. The conflict evident in the client's reply usually signals the difficulty of living with abortion, shame and guilt.

These feelings of shame and guilt, of feeling exposed to a world not condoning a woman's decisions to have an abortion (as indicated below in *Megan's story*), resonate with Michel Foucault's description of the "panopticon" (Fillingham 1993:120). The "panopticon" refers to a prison building designed by Bentham to observe all the prisoners from a central point. Foucault argues that the same concept was later extended to schools, factories, madhouses, barracks and hospitals. Though the prisoners could not see the guard, they knew they were constantly being watched. This "gaze" of the guard resulted in the prisoners watching and disciplining themselves, creating an "internalised gaze".

Foucault's description of the "panopticon" and the accompanying "gaze" indicates something of the predicament of women who are planning or who have had abortions. Apart from the gaze of society or at least of religious communities within society, they experience the internalised gaze – all contributing to feelings of shame and guilt.

I became aware of the fact that one should refrain from passing judgement unless you have been in a similar situation (Allen 1985:201). Megan's story made me realise there is always more to a story than your own interpretation of the story. I had a conversation with Ann, a narrative pastoral counsellor who had an interview with a mother whose daughter had an abortion at the age of sixteen. This woman was silenced for five years until one day when she was subjugated to conversations where judgements were passed, denouncing abortion as murder and sin. The people who raised their opinions publicly were unaware what the effects of their opinions and judgments had on this specific mother. She started her story with the words: "One should never pass judgement if you're not in the situation..."

### **Megan's story**

It all happened when the primary school where Ann was counselling received the Gauteng Education Department's policy regarding teenage pregnancy. Staff members were disgusted at the mere thought of teenage pregnancy and abortion. They uttered remarks like: Surely we wouldn't need a policy like that at a primary school! Abortion, goodness no! That's a sin! Abortion – that's

dreadful! The general consensus in the staff room that day was that abortion was a sin. Shortly afterwards a facilitator/teacher, Megan\* asked Ann, a narrative pastoral counsellor at the school, whether they could have a chat.

Megan's first words to Ann were: "One should never pass judgement if you're not in the situation..." For the first time, Megan told the story about her daughter's abortion at the age of sixteen. It happened five years previously. Up until that day Megan had not shared her story with anyone.

Megan's daughter, Susan\*, had fallen pregnant at the age of sixteen. Susan, now twenty-one, was silenced by fear and could not find the courage to tell her mother about the pregnancy. Though family relationships were open and communication between members relaxed, Susan still found it difficult to tell her mother that she was pregnant. She was ashamed of the pregnancy and fearful of what her mother would say. She felt that it would disappoint her mother and her family. She was worried about what the school would say – it was all too much. She did not know which way to turn.

In the second month of her pregnancy Susan found the courage to tell her mother. Megan had mixed reactions. On the one hand she found it difficult to accept that Susan had found it so difficult to share her pregnancy with her. It concerned Megan that Susan had to bear this alone.

On the other hand, Megan was shocked and left with disbelief. This couldn't have happened to my daughter, she thought over and over. Recovering from the shock and disbelief, she started thinking about the pregnancy and the "problem" the family would have to face. She felt that her husband and son should be informed. As a family they would respect whatever Susan decided regarding her pregnancy.

Megan said that she never once blamed her child for the pregnancy or made her feel that she was an embarrassment, but was able to accept her child. Neither did the family nor Susan blame the boyfriend for the pregnancy.

As a family mother, father, son and daughter, discussed the options. Susan was only sixteen, she was vulnerable and having a child at that age would have had a tremendous influence on her future. She was a brilliant student at school. One of the options the family considered was that Megan and her husband could adopt the baby. After considering all the options, they decided to have an abortion. The decision was made to protect this young teenager's future.

The decision to have an abortion was the beginning of a difficult road. Megan and Susan went from one doctor to another, trying to find someone who was willing to perform the abortion. Five years

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\* Pseudonyms are used to protect the identity of individuals.

ago abortion was not yet fully legalised in South Africa. The family doctor who had treated the family for years was their first option. He was not prepared to do an abortion. He was not even willing to refer them to another doctor. Megan shared with Ann that Susan experienced rejection from one doctor after the other. The shame and guilt she experienced was intense. They made her feel guilty for having had sex at sixteen, falling pregnant and now wanting an abortion.

Eventually Dr Number Five was willing to do the abortion. By that time Megan was in her second trimester. Dr Number Five was rather abrupt and did not explain anything to Susan. They had to accept his attitude. There was nothing else they could do – they had no choice.

Megan accompanied her daughter to the hospital where the procedure was to be performed. This was not the first time Megan had to take time off work, not being able to explain where she was going, pretending that every thing was fine. The silence left the family isolated with a heavy burden to carry. For Megan's husband it was just as difficult to take time from work, being at risk to lose his job. The responsibility of accompanying her daughter and handling the abortion issue was laid upon Megan shoulders.

Susan had to face her own difficulties at school. She had to hide the pregnancy from her friends, teachers and fellow schoolmates. Gym classes were a nightmare, having to undress in front of the other children, worrying that they would notice her pregnancy. She got dressed for gym at home, her school clothes over her gym clothes, trying to avoid embarrassment in the changing rooms.

Megan and Susan were brought to believe that Susan would be in a private room in hospital. That was not the case. When Susan arrived at hospital she was admitted to a four-bedded ward. The medical sister who did the admission was asking Susan detailed questions of her sexual experience, subjecting her to questions that were of no concern – how, where and when did she fall pregnant? The procedure was scheduled for early morning. However, the abortion was only done late afternoon.

The other women in her ward were "mothers" and had babies with them. Susan was traumatised. Megan tried her best to explain the situation to the staff, but they had no empathy whatsoever for Susan. Comments made were: "This will teach you a lesson; you are evil and sinful to get rid of your baby like this; you will be punished." One nurse even went so far as to take a baby right up to Susan and said: "How can you do this? Just look at this beautiful baby." Susan covered her head with the bedclothes and Megan asked them to be quiet. Megan tried in vain to find a doctor to help. She felt torn apart and did not know what to do. For Megan the whole process was just as bad. Megan felt like the worst parent ever. The hospital staff wanted to know from her: "Where were you when your daughter got pregnant?" "Where are your responsibilities as a parent?" "Now you're allowing an abortion!"

She wanted to take Susan home right there and then. On the other hand, she was not sure whether they would find another doctor willing to perform an abortion. At that point, Susan was taken to theatre, sobbing hysterically. Megan felt shattered. Due to the ill treatment by the hospital staff after the abortion, Megan took Susan and left the hospital. Susan was in pain and could hardly walk. This did not bother the hospital staff; they offered no assistance of any kind.

Megan and her husband spoke to Susan about the unfair treatment Susan received in hospital. They spoke a lot about "taking away any guilt feelings" that Susan might have had. The traumatic experience in hospital prevented them from seeking counselling. Susan continued to complete her education at school. Family life slowly returned to normality. Susan now holds a degree and is very successful in her job.

However, Megan needed to speak to someone who would understand and not criticise. She had been silenced for so many years. Something had happened in the staff room that morning that gave Megan the courage to seek counselling. She spoke to Ann for over three hours.

The road to healing was long and tiring. Shortly after the abortion, Megan's son was involved in a car crash and was in a coma for quite some time. It took Megan some time to trust her daughter again. Every time she went out, Megan experienced confusion; she wanted to protect her daughter. She involuntarily thought: "Please don't fall pregnant." Time healed the wounds but for Megan there was no closure to the abortion until the day she spoke to Ann.

The family thought they handled the abortion well. The abortion did not leave Susan with a negative attitude towards sex. Currently she is in a healthy relationship and is comfortable within a relationship where there is trust and caring.

To Ann it was a privilege to share Megan's story and showed much appreciation for the fact that she was trusted enough to become part of Megan's story. Today Ann has a better understanding of the turmoil people go through in a community where judgement is at the order of the day. She learned from Megan that trust was a virtue. Ann, having two daughters realised that an unplanned pregnancy could happen to anyone of them. She admired the way in which Megan never judged or blamed her daughter or the boyfriend for what happened but kept a supportive non-judgemental attitude towards her.

Megan's story touched me. Seeing the other side of the coin of people who are on the receiving end of societies disapproval of abortion.

During my research I asked Nora if she thought that women would still feel guilty were it not for religion. Her immediate reaction was to say no. Then she said that she could not think that a woman, looking at a child,

would be able to feel comfortable with the idea of abortion. She added that she could not imagine that with present-day medical equipment making it possible to monitor the baby's heartbeat and to have a sonar picture of the baby's development, a woman would still be opting for abortion.

I shared some understanding of social construction theory with Nora and suggested that the notion of abortion as sin was actually a socially constructed perception, dating back to 2737-2696 BC . She was surprised and said: "I thought abortion was a twentieth century issue. Perhaps that is why David wrote Psalm 139, describing life from before we were actually born.

Ps 139:15 - 16 in The Amplified Bible (1987) reads as follows:

- 14 I will confess *and* praise You *for You are fearful and wonderful and* for the awful wonder of my birth! Wonderful are Your works, and that my inner self knows right well.
- 15 My frame was not hidden from You when I was being formed in secret [and] intricately *and* curiously wrought [as if embroidered with various colors] in the depths of the earth [a region of darkness and myself]
- 16 Your eyes saw my unformed substance, and in Your book all the days [of my life] were written before ever they took shape, when as yet there was none of them.

Reflecting on these counsellors use of the Bible, prompted me to think about the following quote by Dine (1996:18):

Its use becomes problematic when it forms part of an individual's belief system, and holds authoritative status as 'revelation' or 'Word of God'. Then a tension, often of crisis proportions, exists between the claims of Scripture to be 'true' and the realization that the texts abound in instances where women (whether literally or symbolically) are ignored oppressed or vilified.

Nora mentioned that many of her clients resorted to religion only after they went through the post-abortion counselling process. Then they would become concerned and start to pose questions such as: Am I acceptable to God? Will God forgive me? Did God know that I was going to have an abortion? If he knew, why didn't he prevent it?

Nora said that she would confirm to the client that God loved her and that God knew about the abortion and was willing to forgive her for the abortion. "I take myself as an example. God is always willing to forgive me. Even though He knows that I will err again and again," Nora said.

According to Shostak et al (1984:296), facing an abortion represents one's loss of innocence and illusion concerning the inherent safety or automatic provision of life. When confronted with the reality of abortion, many women for the first time face their own vulnerability and frailty in an increasingly mechanical and uncommunicative world. Brueggeman (1993:31) confirms the vulnerability and frailty that humans face: "In the world of adult knowledge and power, competence, and achievement, we work as hard as we can to deny and overcome our fragility, and thereby to eliminate generosity as a definitional feature and requirement of our life."

## **2.8 Truth and Grace**

The counselling process of Pro-Life counsellors is based on the principle of truth and grace – that healing takes place through truth and grace. They take this notion from Henry Cloud's (1992) book *Changes that heal*. Cloud (1992:15) argues that if there is truth and grace, there can be an intimate relationship between God and his children. Bouwes (1996: 92) echoes this argument: "Being healed is seen as the restoration of the right relationship between God and humanity, which in turn secures a person's position in society."

### **2.8.1 Truth**

The firm belief about truth and grace guides the Pro-Life counsellors in their counselling. To them truth means that abortion is wrong and sinful, however, through the grace of God there is forgiveness and healing and through truth, grace and forgiveness, healing takes place and the relationship between God and his child is restored.

In a post-structuralist discourse, when reflecting on ideas about truth, the question coming to mind is: Who decides what is true? Again patriarchy takes a strong stand as Isherwood (1996a:228) states: "We have been led to believe that a small group of clerical males can decide on universal truths which will benefit all of us." Power cannot be disconnected from truth, since it is people in powerful positions that feel they have the right to define ultimate truth for and on behalf of others.

Landman (2000:62), reflecting on religious intellect says that the myth does exist that religious intellect belongs to white, male religious leaders, believing they are equipped and called to lay down moral laws and have the ability to explain to society how life and death operates. In the same article Landman (2000:62) uses the words "prosecuting society" which to me confirms that if one does not follow the discourse, society starts wondering why you are different. As a result one is labelled and judged. This is not only the case in a pro-life stance, but is seen in the main discourses of life, as in issues of gender, race and class. Reflecting on *Megan's story*, she and her daughter were the victims of a "prosecuting society." The one

group, the hospital personnel, deliberately and knowingly judged the mother and daughter and the other group, the schoolteachers, unknowingly passed judgement.

### **2.8.2 Grace**

Reflecting on the meaning of grace from a theological perspective, Murphy (1996:85) remarks that grace refers to “the unconditional, comprehensive and empowering love of God for all creation. It touches the positive and negative aspects of existence. Grace is related to an understanding of sin and a realisation and understanding that wholeness lacks in creation.” The Pro-Life counsellors strive to convey the grace of God to their clients in order for healing to take place between them and God.

### **2.9 Sin**

Sin as perceived by Pro-Life counsellors implies a serious offence against a religious or moral norm; in this case abortion is considered a serious offence and therefore a sinful act. Taking patriarchy into consideration, women have been taught to be “virtuous” (Tatman 1996a:217) and altruistic. This perception or discourse leaves a woman with no rights over her own body (Faludi 1992). Women taking a pro-choice stance would be considered selfish and egocentric – a definite manifestation of sin. Thus in the abortion debate, being self-sacrificial and self-negating would be seen as virtuous.

### **2.10 Emotional impact of counselling on Pro-Life counsellors**

Being confronted with such defined values, definite ideas, moral beliefs and principles, made me wonder whether these counsellors experienced counselling as emotionally taxing.

Nora confirmed that counselling was indeed very taxing but she believed that was the only way to stay emotionally healthy – being true to yourself and your beliefs. She was of opinion that should one work from a pro-choice stance, counselling would become clinical and one should harden oneself to “survive” the counselling process. She felt that one can make a lot of rational decisions and justify abortion, but when it comes to the consequences, it is only then that reality strikes. According to Nora the latter happens during post-abortion counselling: “Usually the abortion decision is made with the head and it is when the head and the heart clashes that the woman’s problems start.” She maintained that abortion was actually pre-meditated and that pregnancy did not just happen; sexual responsibility was of the utmost importance to prevent unwanted pregnancies.

I asked Nora about her views on abortion as an option in cases of incest or rape. She admitted that it was indeed a very difficult decision to make, but she maintained that God had a purpose with every soul on

earth. Once again she referred to David's Psalm 139, stressing God's plan with our lives even before the creation of the earth. Once again the right of the foetus was put above the right of the mother.

Asking Sandra if she felt the way she was doing counselling was emotionally taxing, she replied that she had taught herself to dissociate herself from the pain of her client. Should she feel that she was becoming heavily overburdened, she would ask her husband to pray for her and to carry the burden with/for her according to Galatians 6:2.

As they all agreed that counselling was emotionally taxing, I was curious to know how and in what way supervision and debriefing were sustaining them.

## **2.11 Supervision**

To the counsellors at the Pro-Life Clinic debriefing during supervision and group meetings were important. At these meetings they shared their experiences and the difficulties they encountered during the counselling sessions. They felt it was through the debriefing process that they had the opportunity to free themselves from the pain and emotion they experienced during counselling.

Mary-Ann said that supervision helped her to remain non-judgemental in her contact with her clients. She experienced the supervision as a learning and growth process. As she had no formal counselling background, she felt that she learnt much from her supervisor who was a trained social worker. She said the supervision gave her perspective on what she tried to do during the counselling sessions.

To Mary-Ann debriefing was an important part of the supervision sessions. When she was doing counselling on a Friday afternoon with no one in the office to share her experience with, she would ponder the interview until the Monday when she could debrief with a colleague.

The counsellors at the Pro-Life Clinic have a self-evaluation form that they have to complete after a counselling session. In this self-evaluation they have the opportunity to reflect on their feelings during the counselling session. Mary-Ann said she would sometimes write FRUSTRATION!!! with exclamation marks. When I asked her what it was during the counselling sessions that made her feel that way, she answered that she had certain boundaries that she could not pass since she needed to respect the client's decision – even though she knew what the consequences of the decision would be.

Nora thought the supervision was beneficial. She felt she needed confirmation that she was on the right track with the counselling. She used supervision as a sounding board to confirm her interaction with her

client. She also felt that during supervision sessions she could really express herself in a way that she was not allowed in front of a client. I explored this with Nora and she said that sometimes when a client decided on abortion, she had to control herself not to tell the client that she was making the wrong decision. Nora admitted that supervision and debriefing prevented her from being heavily overburdened by the pain and circumstances of other women.

When she first started doing post-abortion counselling, remembering her own loss, Sandra felt overburdened by the gravity of the counselling sessions. Since she has learned to dissociate her from her client's pain. Sandra's experience of supervision was that it confirmed her ideas as well as what she was doing during counselling.

Supervision as practiced by these counsellors serves as an excellent opportunity for professional development. In these sessions the counsellors reflect on the ways the clients have touched their lives. Although the counsellors claim to have a non-judgemental stance, they do not reflect on the interaction between the client and themselves by asking themselves or the clients about any instances where they have influenced the clients according to their own value systems.

As the counsellors sometimes struggled not to give their own opinion regarding the decision of the client, I was wondering if it was at all possible to have a non-judgmental attitude towards their clients as they claimed they had.

## **2.12 Non-judgemental attitude**

Mary-Ann said she considered it important to be neutral in one's actions and words. The only way that one could be neutral was by not conveying your own opinions to your client. She tried doing that by saying less than what she actually could have said. She did not know whether her clients were aware of her own inner conflict between what she really believed and what she was conveying to them. It was very important for Mary-Ann that the client made her own decision.

Nora believed a non-judgemental attitude was possible. She would never judge or condemn a woman who decided on abortion or who had undergone an abortion. However, Nora admitted that being neutral under all circumstances would imply that she was not human but something of a robot. "During counselling I help the client to make an informed choice. I would give her all the information. I must add that I would focus more on adoption and parenting than on abortion as an option," Nora said.

I asked Nora about counselling ethics with reference to the fact that the counsellors would never refer or take a client to an abortion clinic. "Quite so," Nora responded, "at our organisation we feel that the client needs to take the responsibility to look up the number of the abortion clinic and make the appointment. This most probably conveys the message that we disapprove of abortion."

According to Sandra the counsellors at Pro-Life have the ability to convey unconditional love to their clients: "When I am asked if abortion is right or wrong, I would answer that I think it is emotionally and physically harmful for a woman but I would never pass a value judgement."

During our conversations, I picked up that the counsellors used the term "baby" and not "foetus". This made me wonder what their opinion was about language and the values attached to language.

### 2.13 Language

Mary-Ann agreed that language could never be neutral and that value would always be attached to language. She said that she would sometimes deliberately use the term "baby" in conversation with a client and in a next sentence would soften it by making use of the word "foetus". She said she was becoming more and more sensitive of the impact of language. She explained her thinking by referring to an example: Instead of saying "A mother gave away her baby," she would rather rephrase to say "A mother made her baby available for adoption."

In our discussion of language, Nora said that during counselling they would never refer to "foetus" but to "baby". They reasoned that the way of speaking and the use of language conveyed to the client the connotation of compassion, care and grace. *Megan's story* shows another side of the use of language – both Megan and Susan felt they were on the receiving end of verbal abuse in the way the hospital staff used the word "baby".

Since language constructs our realities, Sandra suggested *how* you say something to a client could make the difference. Yet she firmly believed that the client had to hear the "truth" and take responsibility for the abortion. She said she aimed to convey "truth" and grace in a soft and gentle manner to the client.

Every time the Pro-Choice counsellors used the word "truth" I was reminded that it was a small group of clerical males who decided on universal truths whom they thought would be beneficial for all (Isherwood 1996a:228).

Mary-Ann refers to herself as a crisis counsellor. I wondered about connecting the "crisis" to "pregnancy" – is it really a crisis or do we transform it into a crisis?

### **2.14 Does God understand the circumstances of abortion?**

Listening to the pain of clients on a daily basis, I was wondering whether the counsellors were wondering what God was making of it all? When *they* hear the dilemmas and pain of the women they counsel, do they think there are instances when God understands the circumstances of abortion?

Nora's view on my musing was that if God was to approve of abortion at all, that He would no longer be true to himself and it would create a precedent as God was the creator of life. Again she referred to Psalm 139.

To that Sandra added that there were many instances when God cried with people. She quoted Psalm 56:8: "You number *and* record my wonderings; put my tears into Your bottle – are they not in Your book?" She reiterated that God had a plan with each and every living soul.

Mary-Ann, the pre-abortion counsellor held a slightly different opinion on this issue. She agreed that there could be circumstances where God would *understand* abortion, but she thought He would never *approve* of it. She drew a parallel between abortion and a crisis such as divorce. Mary-Ann argued as was the case with divorce, abortion was not the ideal situation, but there was always forgiveness with God.

During my conversations with these counsellors, I was wondering if they experienced any personal or professional dilemmas.

### **2.15 Personal and professional dilemmas**

When Sandra first started with post-abortion counselling, she "over identified" with the pain and loss of the client as a result of her own experience. She learned to build a wall between herself and these emotions and to focus on the client emotions only. She was able not to get emotionally involved with the client. She felt she has resolved the pain of her own miscarriage. Sandra became quite despondent when a client would, straight after intensive post-abortion counselling, admit that she would still consider an abortion in future should she require one. Sandra attributed her belief that a client would see things in a different light after counselling to her "fantasy" that clients would somehow be able to opt for the "other alternative" instead of abortion.

At the Pro-Life Clinic post-abortion counselling consists of nine to ten sessions. The fifth session includes the mourning of the client's loss. According to Sandra it is during this session that the client really turns and start with her own healing. In a lot of cases clients terminate counselling before they go through the last five sessions. Sandra finds the termination of counselling frustrating. She made the comment that South Africa lacked literature on post-abortion counselling. One of her goals is to write a book on the stories of her clients in post-abortion counselling.

"Sometimes I feel that I am suppressing my own value system when I am not allowed to speak out," Mary-Ann said. She told of a day when a group of teenage boys and girls (about five couples) came to the organisation and wanted to have pregnancy tests done. One girl was pregnant. She felt the urge to tell them that sex was no game and that they had to realise the consequences of not being sexually responsible.

Due to financial restrictions at the Pro-Life Clinic, Mary-Ann finds it difficult to keep in contact with her clients. At the Pro-Life Clinic, counsellors are not allowed to make phone calls to cellular phones and according to Mary-Ann, most of her clients, especially black women, can only be contacted by cell phone. She finds this financial restriction very frustrating. She would not mind phoning these women from her home at her own cost, but on the other hand, she required privacy to discuss a sensitive issue as abortion.

Mary-Ann feels very frustrated when a client is forced by financial circumstances, for example unemployment, to undergo an abortion because she cannot afford to support the baby. A sense of frustration and sadness sets in when the counsellors at the Pro-Life Clinic receive phone calls from people wanting to adopt white babies. The sadness stems from the fact that there are virtually no white babies available. According to Mary-Anne the availability of white babies to black babies is approximately 1:500. Foreigners seem keen to adopt black babies.

Nora has no personal dilemma in what she is doing. She never feels that her own value system is being touched because she believes in the policy and practice of the Pro-Life Clinic.

Nora feels the need to walk a distance with a client. This does not always happen – some clients only come in for one session. She says she often cries with a client and really wants to be there for the client.

## 2.16 Beliefs and value systems

Sandra: "I have definite values and beliefs regarding abortion. I feel though that I have no right to judge my clients. For me there is no negotiation on the fact that abortion is sin and murder. In spite of this I do not force my own belief system on the client. I still respect the client's beliefs, but my own value system is not negotiable."

During the interview it was clear that Sandra's own value system coincided with the expectancy of the Pro-Life Clinic and that she had no discrepancies in herself regarding the way in which she did her counselling.

Mary-Ann: "I used to think abortion was acceptable in some instances, such as rape, incest and where abnormalities were detected. Now I realise that I cannot condone abortion. I believe that life begins at conception."

Nora's beliefs and value systems correlates with those of the Pro-Life clinic.

Nora: "Before my involvement with the Po-Life Clinic I was of opinion that abortion in cases of rape, incest or deformity was acceptable. My opinion has changed and I am of the opinion that no matter how conception has taken place, it is about an eternal soul and that God has a plan with each baby that is conceived."

The counsellors at the Pro-Life Clinic have a definite view of abortion – it is wrong, sinful and murder and is in no way negotiable. In spite of their view, they believe that they have a non-judgemental attitude towards their clients. In spite of the counsellors' own fundamentalist value systems, they would never voice their own opinion about abortion unless asked for it. Whenever a client makes the decision to undergo an abortion, they refrain from being judgemental, even if it is a third or fourth abortion. I think this creates quite a personal dilemma within the counsellor not being able to tell the client not to proceed!

Although these counsellors do not tell their clients (in so many words) that abortion is "wrong", there are various ways in which the value position of the counsellor can be camouflaged in the counselling process. This value position is stated through the fact that a client would never be referred to an abortion clinic even if the client has made the "informed" decision for abortion. Another value position that embedded in the counselling process is that counselling takes place from the assumption that abortion is murder and sin and sustainable healing from abortion can only be obtained through repentance and forgiveness.

With reference to chapter three, where I discussed value free counselling, I would like to quote O'Brien (1984:14) again "Counsellors' values are an integral part of the counselling process and they do influence both the process and outcome... Values influence goals, techniques and the justifying of theory; in short they influence everything."

In line with O'Brien's argument, I find it difficult to believe that these counsellors are able to work from a non-judgemental stance. They respect the value system of the clients, because it is their preferred reality, though, if the counsellor does not express his or her stance verbally, his or her stance can be conveyed to the client through body language. I have experienced that clients who are in emotional pain or a dilemma are far more sensitive to attitudes, gestures and judgements from counsellors.

Due to their professional knowledge, counsellors are in a power position in the counselling process. This power should not be misused as clients value the opinion of the counsellor. Counsellors should be aware that they do not influence the client according to their (the counsellors' own) value system.

### **3. Reflection**

In this chapter I reflected on the Pro-Life counsellors counselling from a stance that protects the right of the foetus. This is not the only value presented by these counsellors and during the interviews a large number of value aspects came to the fore.

These aspects have been discussed in the paragraphs above and include issues such as prayer, religion, murder, sin, guilt, truth, grace and language. I noticed that different discourses from the mentioned issues as well discourses not explored came to the fore and became the individual counsellor's set of inherent and underlying direction during counselling.

In these paragraphs I reflected on the counsellors, their values, different literature perspective as well as my own perceptions from the interviews. To reflect on these again would only be a repetition but the more prominent ones are reflected on in the following paragraphs.

Although we have covered a wide range of relevant issues in our conversations, I left the Pro-Life Clinic feeling that not all my questions were answered. However, is that not what research is all about – not finding answers to questions, but realising that there are always more questions sprouting from the identified questions? Is that not the spirit of social construction shining through? Gergen (1991:137) comes to mind: "For once it is realized that all attempts to 'tell the truth,' to be wise, insightful, intelligent or

profound, are constructions of language...then it becomes very difficult to make a deeply serious investment in such tellings."

I was wondering about how a client would have experienced the counselling process at the Pro-Life Clinic and specifically in regard to the following:

During counselling, the client would be informed about her options regarding the unwanted pregnancy and she will be asked if she wanted to know about the abortion process "because it is a very dark process." The women (the clients) are not always aware of what to expect and could be traumatised by the medical side of the abortion procedures. *Megan's story* illustrates this aspect quite well.

I also wondered about the notion of being non-judgmental. If the policy of the organisation does not allow the counsellor to refer a client to a abortion clinic or even accompany such a client for moral support, is the message implied not one of "I do not approve of your decision"? Does this not further imply a judgemental attitude towards the client? The words of Rose Wo (2001) come to mind – "Women have independence over their bodies while on the other side of the mirror they have to shoulder decisions as being right or wrong on their own." Is abortion not an issue that goes beyond right and wrong?

Finally, they decided to give up the baby. The decision made their hearts feel better but no lighter. The surgery was carried out successfully. That night Autumn named the baby and wrote her/him a prayer explaining why she was not able to give her/him birth. In prayer, she said, 'Mummy is so useless. I thought that I didn't have any ability and confidence to welcome you into the world. I am sorry! I desperately want to know what you look like and desire to hold you in my arms. Although I denied your chance to live on earth when you were a few months old, our relationship will go on and on. I hope you will forgive me.' Autumn feels hurt because through her experience she discovered that life is never perfect. However, she has consolation in her beliefs she said: 'Through this experience, I built up a new relationship with God, not a relationship based on judgement and suppression, but on liberation.' Perhaps because of the non-interrupted 'conversation' with her child, these conversations relieved and consoled her heart.

(Wo 2001)

Wo (2001) confirms that abortion is never an easy decision. She also implies that women do not necessary feel judged by God or feel they have committed a sin. I believe it is through religious discourse that women are made to feel guilty and judged when deciding on abortion.

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges within themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?* Reviewing my research question and reflecting on my conversations with the Pro-Life counsellors, I would suggest the following:

The most basic value-challenge the counsellors at the Pro-Life Clinic experience is to negotiate between their own belief system and that of the client. They made it clear that they are not forcing their own belief system onto their clients. As a matter of fact, they claim to maintain a non-judgmental attitude. The counsellors at the Pro-Life Clinic actually only need to negotiate value challenges with themselves and with the clients because of the following:

**Self:** Though the selves of the counsellors are in harmony with the contents of their counselling at the Pro-Life Clinic, inner conflict is experienced when they are not able to speak their minds and tell the clients that what they are doing or planning are due to have painful consequences. They strongly believe that abortion, whatever the reason or circumstances, is wrong, it is a sin and it is murder because "God has a plan with every soul". The way they go to negotiate this, is to rely on guidance from the Holy Spirit.

**How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other and their supervisors:**

Regarding their values, religious beliefs, relationship with the Other and the supervisor the counsellors feel that they do not need any form of negotiation as their own beliefs do correspond with the policy of the organisation.

**The counsellors had to find a negotiation process with the counselee:**

The counsellors are challenged to keep a non-judgmental attitude towards the clients. If they know that the client is going for an abortion, they make use of truth and grace as described in paragraph 1.8. When a client decides on abortion, the counsellor negotiates these conflicting values by saying that the client is responsible for her own decision. The counsellors emphasise the responsibility of the client, saying that it is not the doctor, mother, partner or counsellor's responsibility but the clients own. This brings the sole responsibility of whatever the effects of the decision might be, back to the client.

For the two post-abortion counsellors at the Pro-Life Clinic it is a very important factor to convey the "truth" about abortion to their clients. They believe that the Lord will always provide the right moment during the counselling to do this. I can understand their feelings of being true to God and the Holy Spirit to convey truth and grace to their client, but I am still confused as to how a non-Christian would understand truth and grace. I can accept that if the Holy Spirit convinces these counsellors that abortion is murder and a sin that they will abide by it since to them it is the Ultimate Voice. The latter confirms the way in which way these counsellors truth is socially constructed.

The Pro-Life counsellors said they could not answer any of the questions on adoption. Mary-Ann described her sparkling moment of being part of an adoption ceremony, however it occurred to me that she never asked the biological mother what her experience of the adoption was. She described adoption as "the most unselfish thing a woman can do"(refer Annexure E). This made me wonder if it was ethical of counsellors only highlighting the effects of the alternative that we, from our own point of view, do not approve of. On the other hand the pre-abortion counsellor said that she would sometimes rather say less during a counselling session in order to keep her from influencing her client and allow the client to make her own decision.

During my conversations with these counsellors they confirmed their values and value systems about abortion. The post-abortion counsellors are adamant that there is no negotiation regarding their views or values regarding abortion.

The pre-abortion counsellor said that she sometimes had to negotiate with God through talking, praying and asking forgiveness after she had counselled someone and could not tell the woman directly that what she was planning was wrong.

In the conversations with these counsellors it became clear that these counsellors could not dissociate themselves from their religion during counselling since it was their spiritual beliefs that directed them during counselling.

I asked one of the counsellors: "Do you think it is ethical not to continue with counselling beyond a certain point? What I had in mind, was the practice at the Pro-Life Clinic not to refer a client to an abortion clinic or assist her through the process.

The counsellor did admit that this could perhaps be unethical. Although they never say to their clients that they do not approve of abortion, this must confirm their disapproval to the client.

I conclude this chapter with a remark by Andrews and Kotzé (2000:334):

How can we as therapists assist in the development of different self-narratives, when spirituality contributes to the problem-saturated story, without defining it as causing the problem? The challenge for a narrative therapist would be to deconstruct these "truths" and find an alternative, freeing, enabling spiritual talk.

## Chapter Five

### Reflection on interviews with Pro-Choice counsellors

#### 1. Introduction

In this chapter I reflect on interviews I had with Pro-Choice counsellors. As in chapter four, the focus was on my research questions: *What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

During my interaction with the Pro-Choice counsellors, the following themes emerged: professional backgrounds of these counsellors; their professional and personal stance; a strong belief in forgiveness; the role of the church in their personal and professional lives as well as a calling and a non-judgemental attitude towards their clients.

#### 1.1 Background and qualifications

Two of the nurses, Angie and Gladys, were fully qualified sisters and midwives, while Damaris was a staff nurse. Midwives had to be registered by law under Act No. 50 of 1978 (that replaced Act No. 45 of 1944). Only then could a midwife perform an abortion if such training was part of her curriculum. A staff nurse was only able to assist during the abortion procedure but was not qualified to carry out an abortion.

Midwifery and herbalism were practiced since the Middle Ages (Bouwes 1996:93) and skills were passed on from mother to daughter or between female relatives. For centuries no formal training or registration at any medical board or society was required. During 1944 it became compulsory for practicing midwives to be registered under Act No. 50 of 1978.

#### 1.2 Experience of previous employment

These counsellors were previously employed at government hospitals but found it more satisfying working at a clinic such as Pro-Choice. Damaris, the staff nurse, experienced quite a lot of verbal abuse when assisting abortion patients at a government hospital. The overall attitude from the medical personnel, who were pro-life, was very hostile. It seemed that it was not only these counsellors who faced the dilemmas and consequences of a pro-choice stance. Nurses who performed abortions claimed that they were frequently overlooked for promotion (Taitz 2000a). This information could imply that people with a pro-life stance opposed people with a pro-choice stance – not only emotionally but also by making it difficult for Pro-Choice counsellors or health workers to find employment and to voice their opinions.

After the introduction of the Choice on Termination of Pregnancy Act No. 92 of 1996, and with the opening of the Pro-Choice Clinic, Angie was successful in her application for the position as manager at the Pro-Choice Clinic. Before she could take up her position at the clinic she had to attend intensive workshops to prepare her for the work at the Pro-Choice Clinic and to be fully informed about abortion.

During my interaction with these counsellors, I experienced them as very confident and comfortable with their pro-choice stance. It was this attitude of confidence that made me wonder if there were any discrepancies these counsellors experienced regarding their personal and professional stance to abortion.

### **1.3 Professional stance**

Regarding their professional stance these counsellors had no hesitation whatsoever. They thought what they were doing, was necessary. The feeling I experienced and the message they conveyed throughout my interaction with these counsellors was that they were providing a service to the community.

Angie said she was employed at government hospitals and assisted with abortion since the Abortion and Sterilization Act No. 2 of 1975 was promulgated in South Africa. She believed that the Act on Termination of Pregnancy of 1996 was just an extension of the Abortion and Sterilisation Act No. 2 of 1975. According to Angie abortion was always available but the psychological, emotional and social factors were never taken into consideration for women who were faced with an unwanted pregnancy.

Though Angie and Damaris had no hesitation whatsoever that there was nothing wrong with abortion, they negotiated the "if abortion is wrong" through the absolute faith in the forgiveness of God which they believed was accessible and obtainable through prayer.

### **1.4 Personal stance and forgiveness**

Angie, the clinic manager and Damaris, the staff sister believed that abortion was a service they provided to the community. Angie emphasised that one should take in consideration how many back-street abortions were still being done; how many woman died because of back-street abortions; how many babies were found dead in dustbins and gutters and how many babies did not get adopted. As Angie was making these remarks, I was wondering about how many babies were born HIV-positive with very little life expectancy or would be orphaned because of parents dieing of HIV-Aids.

Angie said there were so many sins, "Why do people who sin, condemn abortion?" She firmly believed in God's forgiveness. She referred to the story of Jesus and the adulterous woman in John 8:3-11. She

stressed the Lord's forgiveness and the fact that no one picked up a stone to kill the woman because they were aware of their own sins.

John 8:3-11 reads as follows in the Amplified Bible (1987):

- 2 When the scribes and Pharisees brought a woman who had been caught in adultery. They made her stand in the middle of the court and put the case before Him.
- 3 Teacher, they said, This woman has been caught in the very act of adultery.
- 4 Now Moses in the Law commanded us that such [women-offenders] shall be stoned to death. But what do You say [to do with her- what is Your sentence]? [Deut.22: 22-24]
- 5 This they said to try (test) Him, hoping they might find a charge on which to accuse Him. But Jesus stooped down and wrote on the ground with His finger.
- 6 However, when they persisted with their question, He raised Himself up and said. Let him who is without sin among you be the first to throw a stone at her.
- 7 Then He bent down and went on writing in the ground with His finger.
- 8 They listened to Him, and then they began going out, conscience-stricken, one by one, from the oldest down to the last one of them, till Jesus was left alone, with the woman standing there before Him in the center of the court.
- 9 When Jesus raised Himself up, He said to her, Woman, where are your accusers: Has no man condemned you:
- 10 She answered, No one, Lord! And Jesus said, I do not condemn you either. Go on your way and from now on sin no more.

Based on this passage from Scripture, the counsellors negotiated their uncertainties about the "sinfulness" of abortion. The forgiveness of the Lord was something they firmly believed in.

The fact that both the pro-life and the pro-choice counsellors used exactly the same Scriptures (John 8:3-11) to demonstrate God's forgiveness, once again confirmed that no objective truth and knowledge existed. This confirmed once again that knowledge was socially constructed as I have indicated chapter two paragraph 2.2. It also confirmed that women working from specific stances (pro-life or pro-choice) had to be understood as their actions were an expression of a specific social context (Reinharz 1992:43).

Tatman (1996a:217) argues that for many years there have been sinned against women. Women are blamed for bringing sin into the world and for continually tempting men into sin. Considering abortion, it can once again be argued that women are sinning by taking a pro-choice stance, or for that matter, taking control over their bodies and their own reproduction.

Gladys was unsure whether abortion was right or wrong and sometimes really got "mixed up". She said: "I don't know what God thinks, I don't know if He thinks abortion is right or wrong. I sometimes feel judged by God.". McFague (quoted in Andrews & Kotzé 2000:325) contends "a person's ideas of God are influenced by a plurality of perspectives, including our religious language, our class, race, gender, nationality and family, background, interests, prejudice and concerns". I was wondering if Gladys was not confused because of one specific tradition of the image of God as it was conveyed in the "religious language" of her husband's church. Though Gladys struggled with the "right" or "wrong" of abortion, she did not allow her personal struggle to influence or marginalise her clients in any way. Though she was confused at times, she would never let this confusion influence her when she facilitated abortion counselling. It was her goal that the client could make an informed choice.

She negotiated this discrepancy (the "right" or "wrong" of abortion) in prayer. (Prayer is discussed in chapter four paragraph 2.5). She would ask for forgiveness and would reason that abortion was a choice one had to make. Although she had this inner conflict, Gladys thought she probably would not have worked at the Pro-Choice Clinic if her family did not approve. Her family was supportive and accepted what she was doing. She felt she did not have to convince them to support her in her career.

### **1.5 Counselling**

According to Angie, when a woman comes to the Pro-Choice Clinic, she has already decided about having an abortion. The counselling done at the Pro-Choice Clinic includes providing her with all the information in order to empower her to make an informed decision regarding her pregnancy. Angie's experience was that women seeking an abortion have already been to a minister, a psychologist or a Pro-Life Clinic for counselling. They came to the Pro-Choice Clinic to go through with their decision.

If the client was sure about her decision the abortion could proceed. If the client was not yet sure about the choices she had, or what the abortion procedure consisted of, the counsellors at the Pro-Choice Clinic would inform her about the available options she had.

After the client has been informed about alternatives to abortion (foster care, adoption and single parenting) and still wanted to proceed with the abortion, the procedure as well as the equipment that would be used, would be explained and shown to the woman.

### **1.6 Language**

I was wondering about the language that these counsellors used during the counselling process. The Pro-Life counsellors' use of the term "baby" made me wonder what term the Pro-Choice counsellors would use.

They confirmed that they never use the term baby, but would prefer the term "foetus". I was curious about the instruments used during the abortion procedure and asked one of the counsellors to show and demonstrate the instruments to me. I deliberately asked what they called the "substance" that was removed from the uterus – wanting to know if it was a baby or a foetus. I was informed that the substance was called "the product". I interpreted the term as an attempt to refer to a foetus in a neutral way and to avoid any form of value judgement. This resonated with the language used in the Choice on Termination of Pregnancy Act No. 92 of 1996 where the term "removal" is used instead of "killing". This language matter again confirmed that language cannot be neutral – there is always value attached to language.

Reflecting on the word "product" once again reminded me of the instability of meaning in language. A product could only be a something that was *produced*, something that was part of a creative process producing a product.

The counsellors' experience contributed to their understanding of the circumstances of the women requesting abortion. They were acquainted with the environments and conditions the women came from and refrained from asking personal questions and burdening the women with irrelevant issues. The interview with Ann, the narrative pastoral counsellor in chapter four, confirmed how painful it was for the sixteen year old Susan and her mother when the health worker who admitted Susan to hospital for the abortion procedure, asked her irrelevant questions about how, where and when conception took place.

Reflecting on the attitudes of the Pro-Choice counsellors, I realised that they acted in a way that did not make their clients feel uncomfortable or burdened by unnecessary questions. I realised that they were trying to keep in mind that abortion was a difficult decision to make and that even if the consequences were painful, it did not imply that it was the wrong decision (Neuger 1996:140).

I was convinced that the counsellors at the Pro-Choice Clinic were sensitive and would never influence a client to proceed with an abortion unless she was one hundred per cent sure of her decision. Yet, I still wondered whether fewer women would decide on abortion if the counselling sessions were more intense and if clients were required to attend more than one counselling session before coming to a final decision.

The counsellors found that women were not so much emotional about the abortion itself as frightened of the physical pain following the procedure. They were also afraid of possible complications. Some women would cry after the abortion was done because they felt guilty. The counsellors would assist them and offer them the opportunity to cry. They would also encourage them to visit the clinic again for a follow-up visit. The clients usually came back for a medical check-up after the abortion. During this session, the

counsellors would enquire whether the client was coping. Should they find the client was traumatised or very emotional, they would refer the client to a psychologist or a Pro-Life Clinic for post-abortion counselling. The Pro-Choice Clinic did provide post-abortion counselling and seldom had clients requesting post-abortion counselling.

The Pro-Choice counsellors' experience was that in general abortion patients coped well after abortions. They said some of their patients often popped in at the clinic just to say hello. The non-judgemental attitude of the counsellors in their approach to care was evident in the way they described their work. Moreover, their care reflected something of "a social practice where care is socially constructed by care-givers as well as care receivers" (Kotzé & Kotzé 2001:7). To my mind this attitude would resemble the spirit of doing pastoral care and counselling.

All three counsellors agreed that if they sensed the slightest doubt in the client regarding an abortion, or should the client be accompanied by a boyfriend, friends or family encouraging her to go for an abortion, that they would ask the client to take more time to reconsider and to come back later. They would make it clear to boyfriends, friends and family that the decision was entirely up to the woman.

Being able to convey a non-judgemental attitude to their clients, I was wondering if there were any circumstances in which these counsellors faced professional dilemmas.

### **1.7 Professional dilemmas and a non-judgemental attitude**

The Choice on Termination of Pregnancy Act No. 92 of 1996 states:

Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;  
Believing that termination of pregnancy is not a form of contraception or population control...

The stipulation that termination of pregnancy was not to be seen as "a form of contraception" left pro-choice counsellors with the responsibility of introducing contraceptives to their clients, even more so when clients would return for a second or third abortion. It was common practice that a woman would not leave the Clinic without contraceptives.

The counsellors felt rather disheartened when a woman would come back pregnant saying that the contraceptives made her nauseous or worse, that it made her fat. The counsellors tried to understand that ignorance and illiteracy played a role in the effectiveness of contraceptives.

In spite of using contraceptives, some women still became pregnant. The counsellors felt that if the client did take precautions and still became pregnant, they had no reason to judge her.

Angie said she felt sorry for a woman who went for a second and a third abortion, especially if they planned to have children in the future. The effect of multiple abortions was the thinning of the uterus membrane. After several abortions the membrane might become too thin for the placenta to attach to it.

Gladys said that sometimes clients wanted to know if she enjoyed her work. She said she interpreted the question as meaning did she approve of what they were doing. Her standard answer though, was: "I am very happy in my work and enjoy doing it."

Damaris remarked that being non-judgemental was a way of being. She enjoyed providing a service to clients, to see the relief and thankfulness on their faces when the abortion procedure was done. She enjoyed the interaction with different people and experienced her profession as tremendously satisfying and fulfilling. She stressed the fact that she had no right to be judgemental towards women whose circumstances did not allow them to continue with a pregnancy.

### **1.8 Supervision and debriefing**

If a problem of whatever kind should come up in counselling, there would be a discussion between the supervisor and the counsellor. Angie said that seldom happened. In the day-to-day practice of the Clinic counsellors did not feel that they needed debriefing or supervision. Damaris said that she enjoyed her work so much that she did not consider supervision or debriefing necessary.

According to Angie the government arranged quite a lot of workshops for health workers. She felt the workshops served a good purpose to meet other health workers and discuss related issues, experiences and difficulties with one another.

I believe the counsellors felt so comfortable with what they were doing because they sincerely believed in what they are doing – believing that what they were doing could bring about positive changes in other women's lives. This belief in what they were doing could be the reason why they did not have an intense need for debriefing and supervision. They did not seem taxed or burdened by what they were doing.

### **1.9 Role of the church and families**

Angie made the rather poignant remark that society was suspicious of abortion because the church as a dominant opinion former did not approve of abortion. It was not until politicians (as another dominant group

of opinion formers) introduced legislation that society's view of abortion had been challenged. "If you don't understand it, you react to it", she said. She argued that so many people reacted to abortion practices on religious grounds without ever being in a situation where an abortion had to be considered an option. She said a person could not voice an opinion without ever being in that particular situation or close to someone in that particular situation. Megan's story (chapter four) could serve as a resounding example of what Angie was saying. Angie added that the vociferous women campaigning against abortion often were women who had passed the childbearing age.

Angie felt that the church was silencing the voices of women. According to her preaching abstinence was not a realistic solution to unwanted pregnancies or Aids since humans were created sexual beings.

Angie told me about a client from the Roman Catholic Church who participated in an anti-abortion campaign (she described it as *toyi-toyi*). The day after the campaign she came to the clinic for an abortion. Angie asked her about her participation in the *toyi-toyi* and she said that she was not at liberty to say that she was pro-choice. Angie thought this was a good example of the judgement mentality of the church, silencing women, leaving them voiceless and sometimes with no support system when they needed to make a decision regarding an unwanted pregnancy.

I cannot but reflect on the recurring theme of the role of institutionalised religion in the abortion debate. Angie's references to religion and the church, commonly perceived as the vehicle for religion, brought me face-to-face with the marginalising effects some religious prescribers have on women contemplating abortion. If religious denominations were to take responsibility in supporting women who were contemplating abortion, allowing them a new spiritual, self-narrative (Griffith & Griffith 1993:6) regarding their choice, they could play an active role in healing in women's lives. However, the contrary seems obvious. Instead of playing an active role towards healing, it seems as if the power religious denominations have (and they have power!) and the power attached to the dogmas being preached, serve to colonise the minds of those with no power. Hare-Mustin and Maracek (1988:458) argue this point when they say that "those in power advocate rules, discipline, control and rationality, whereas those without power espouse relatedness and compassion".

The one thing all three counsellors agreed on was that different churches condemned and judged women who have decided to go for an abortion – perhaps only in different ways and with differing levels of conviction. On the other side, the church's position on abortion, as clear as it has been advocated by religious leaders, seemed not to include support of a woman should she decide to keep the baby. Albeit a generalisation, there is some truth in the perception of the counsellors that the church hardly ever budgets

to support the woman who has decided to keep the baby; to help her financially; to help her through the pregnancy and to help her raise the child.

All three counsellors regarded themselves as committed Christians.

Angie, a member of the Methodist Church, extended her role as health worker to the church where she lectured the youth on family planning, abortion and counselling. I came under the impression that Angie was doing theology not only at church but also at the clinic where she was employed and in her own community. She was doing contextual practical theology (Pieterse 1993) focusing on society's political, economic, developmental, ecological and medical problems.

Angie's husband and children were aware of what her job required and supported her fully. Sometimes on a Saturday, her children would spend the day with her at the clinic.

Damaris was a member of the Apostolic Church. Damaris said her church regarded abortion as sin. However, Damaris repeatedly said that she had no doubt about her job at Pro-Choice Clinic. She did not have a husband but her children knew what she was doing and approved of their mother's job. In fact, she said they would often wear their T-shirts promoting the Clinic.

Gladys was a member of the Dutch Reformed Church and her husband a member of the Roman Catholic Church. When she would visit the Roman Catholic Church with her husband, she "felt guilty" since the priest was rather vocal in his condemnation of abortion.

Gladys had the support of her husband and children in the job she was doing and this sustained her.

### **1.10 Calling**

I was taken by surprise when the counsellors mentioned that they considered their work at the Pro-Choice Clinic as a calling from God. For the first time during my research, my own discourse of holding on to a pro-life stance was seriously challenged. I caught myself thinking that working at a Pro-Choice Clinic could not be a calling from God. Reflecting on this thought, (working at a Pro-Choice Clinic could not be a calling from God) I realised that I held a pro-life stance where I believed that abortion is a sin and wrong and that it did not fit with my religious beliefs. My conversations with the Pro-Choice counsellors made me realise that I was holding on to a religious discourse, not knowing what it looks like on the other side when one faces an unwanted or unplanned pregnancy. These conversations with the Pro-Choice counsellors challenged

my pro-life stance and I realised that my focus was beginning to change from pro-life to pro-choice with much understanding of *why* women decide on abortion.

To the pro-choice counsellors the service they rendered was needed by society. They regarded abortion as a decision to be taken in adverse circumstances and they felt that they were there to help people in those situations.

My conversations with both Pro-Life and Pro-Choice counsellors allowed me opportunity to consider my own understanding of abortion counselling as "a calling from God". Both my conversations and my understanding were informed by a social constructivist view of reality – that there was no "objective and universal truth" (Brueggemann 1993:8). It became more and more acceptable to think of both Pro-Life and Pro-Choice counsellors experiencing their involvements in abortion work as "a calling from God".

Although it seemed obvious that the counsellors were working from opposing stances, the common denominator was their commitment to their calling. Once again I became aware of truth as multi-faceted – not as ultimate, objective and universal.

There has always been a close relationship between truth and power. Since the days of early Christianity people who dared to question the authority of the definers of truth were punished. Today they are suspended from teaching and preaching positions. Isherwood (1996a:228) states that the challenge of feminist theology lies in declaring the truth as found by living in relation to one's community and environment. This notion applies particularly to women of colour who are economically deprived and marginalised. Is women's truth not the issue when women faced with an unwanted or unplanned pregnancy have to make a decision on abortion? It seems that "truth" is to be found between people as they deal with the challenges of everyday life as Isherwood (1996a:228) argues.

## **2. Identifying discourses that influence abortion counselling**

### **2.1 Capitalist discourse**

Damaris said that white women usually have abortions done before the twelfth week of pregnancy, while black woman would have it done after the twelfth week of gestation because they did not have access to have an abortion done earlier. I was asking myself: If one didn't have money to pay for an abortion, how would one be able to support a child until he or she became independent? Furthermore, did society have the right to judge the act of abortion without knowing the circumstances of the woman? I also wondered how many of us contributed to the fact that woman needed to seek abortion as a result of financial limitations because of society endorsing patriarchy and inequalities in race and gender?

Abortion done at a late stage of gestation is a controversial issue and moral questions seem to increase when an abortion is done later than the first trimester of pregnancy. Abortion after the first trimester becomes more difficult for both the woman and the medical staff. The foetus is in an advanced state of development, making the abortion procedure more strenuous on the woman and increasing risks to her health.

A factor contributing to abortions done at a late stage of gestation is that women cannot always afford abortions in private clinics and consequently have to depend on government hospitals. Government hospitals are burdened by an enormous backlog since only a certain amount of abortions are scheduled per day (Althaus 2000). Another dilemma women requesting an abortion at a government hospital are facing, is being marginalised by pro-life health workers.

Pro-Choice Clinics counteracted abortion at a late stage of gestation by providing services at some of their clinics at minimal cost. Another pro-active way of preventing abortion was to provide woman with information regarding contraceptives as well as the provision of contraception.

## **2.2 Religious discourse**

From conversations from the pro-choice counsellors, I came under the impression that religious discourses burdened women and counsellors with feelings of guilt regarding the choices they were making. The feelings of guilt came from judgements being passed by certain (religious) groups in society. The message coming from religious groupings could be quite confusing. Jantzen (1993a:2) highlights some of the discrepancies present in religious discourse:

There have also been objections, not only by Catholics, to sex education at school, and allowing teenagers access to contraceptives, while at the same time denouncing teenage pregnancies, single mothers and teenage women who seek abortion.

Reflecting on Gladys' comment: "I don't know what God's opinion of abortion is", made me wonder if God understood woman's realities of pregnancy, childbirth and parenthood. The Bible uses metaphors to describe God as feminine. In Luke 13:34 the metaphor of a "hen" wanting to gather her young under her wings is used. Isherwood and McEwan (1993b:131) remark: "A number of women who have felt devalued and powerless within society find the notion of Goddess an enlivening and strengthening concept." Thinking of God in a female way has possibilities for the empowerment of women while the non-inclusive language and patriarchal dominance used in the Bible (Murphy 1996c:186) foster a sense of powerlessness and alienation.

My experience in this study was that religious discourses tended to marginalise and silence women. These discourses contributed to the fact that women seeking abortion, experienced religion as strict and punitive resulting in a perception of God as an enemy, as someone who did not only condemn abortion, but also the person who opted for an abortion. The religious understanding of women seeking abortion or post-abortion counselling was influenced by men who decided on universal truths they thought would be to the benefit of all. "Feminist theology is questioning the notion of absolute truth and the idea that it can be applied in a standard form to all people" (Isherwood 1996a:228).

### **3. Reflection**

Reflecting on the interviews with the Pro-Choice counsellors, I had a feeling of "lightness". Thinking about this "lightness" I came to realise that it was some sort of relieve to realise that there was an alternative to an unplanned or unwanted pregnancy without being judged because of one's decision, should that decision be abortion.

Reflecting on the counsellors' spirituality, their belief in God and their confessions of being Christians, I realised that they did not feel that their beliefs needed to be shared with their clients. The way in which these counsellors were practicing, confirmed to me that they were actually doing theology, bringing about change in people's lives without being judgemental. This was actually confirmed by the fact that they felt they lived out their calling through the service they rendered at the Pro-Choice Clinic. Their stance conveyed an attitude of acceptance towards the client.

Being black, I thought these counsellors had first-hand knowledge about the circumstances of their sisters and neighbours. They understood the background and could relate to the circumstances of these women.

Neuger (1995:133) says the following about women who have a pro-choice stance:

The pro-choice woman knows that mothering, especially unplanned mothering, may destroy her economic and employment security and leave her vulnerable to sex discrimination in the workplace.

With reference to my research questions, I realised that these counsellors have found a way of negotiating their values through the forgiveness we all receive from the Lord when we did something wrong. These counsellors felt comfortable with their beliefs and value systems because of their firm belief that one's circumstances should determine one's choice. Angie remarked that we were so worried about being right or wrong or about eternity that we neglected to focus on the important issues in this life, on the here and now.

To me this confirmed Angie's way of doing theology, bringing change in people's lives in the here and now we are living in.

Though I did not interview women who had abortions or who were considering an abortion, I realised how restrictive spirituality be, binding and narrowing down people's stories. With reference to Megan and Susan's story in chapter four, not only their story was narrowed down, but they were completely silenced through spiritual stances such as abortion being viewed as a murder, sinful and disgusting

The counsellors at the Pro-Choice Clinic's preferred spiritual talk consisted of the belief in the unconditional forgiveness of God. I learned from them the value of challenging and deconstructing restrictions of spirituality. It once again confirmed that one should not be blinded by "one objective truth". I would like to side myself with Isherwood (1996a:228):

The imposition of truth is not a liberating way to live because it assumes that all is known and that people have to mould themselves to fit with the already revealed path.

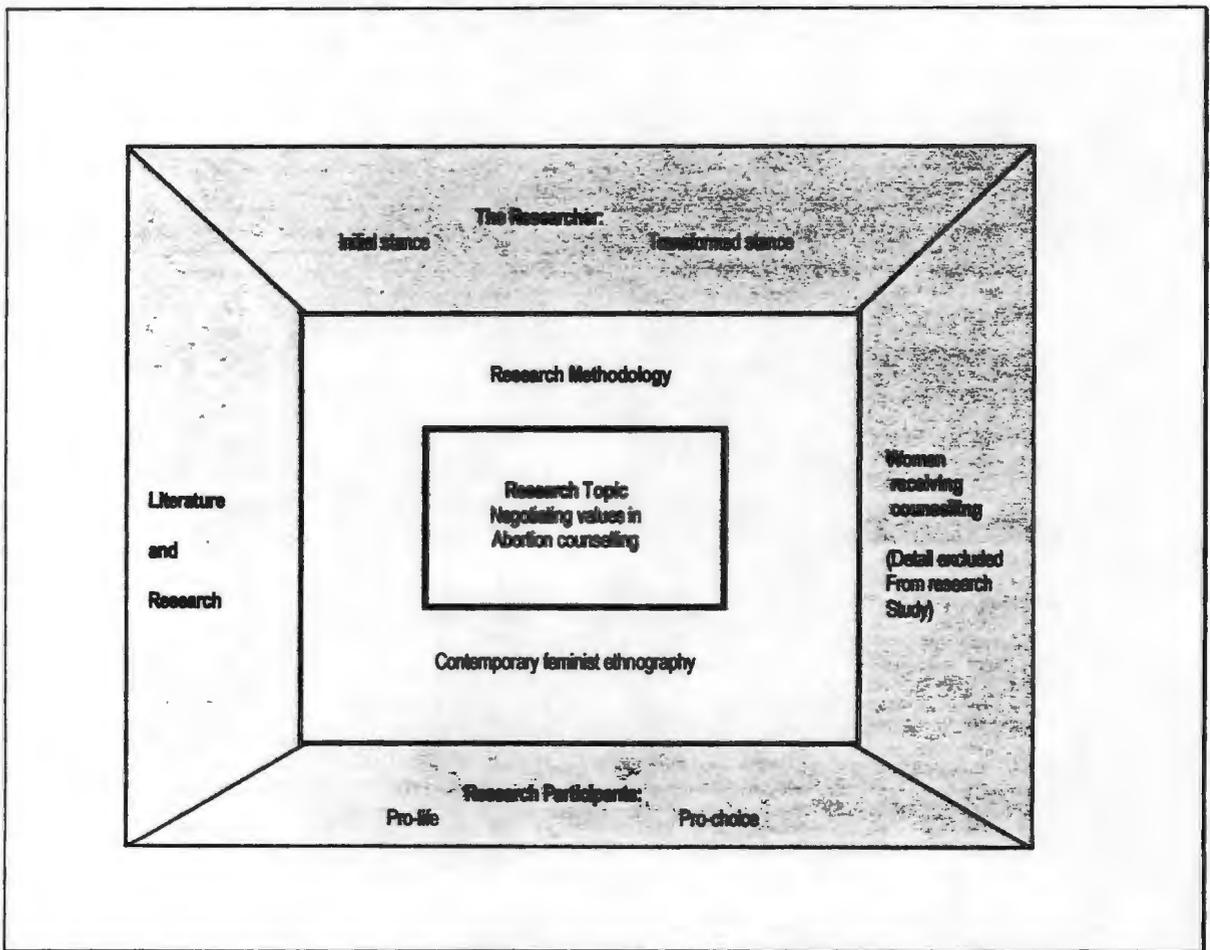
## Chapter Six

### Reflecting on research

#### 1. Introduction

In this chapter I reflect on the research topic, research methodology and the contributions of the research participants who assisted with the research. All these areas had been individually presented and reflected on in previous chapters of this research study.

The approach adopted is presented in diagram 1 below:



**Diagram 1: Schematic diagram of the subject areas of this research.**

The centre of the reflection is the research topic that flows through to the other subject areas via the research method, contemporary feminist ethnography.

#### 2. Research topic

The research questions as defined in chapter one are as follows:

*What are the value-challenges that abortion counsellors experience? How do abortion counsellors negotiate these challenges with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees?*

Derived from the research questions issues such as values, value systems and ethics were discussed in chapter three. During the course of the research study other closely related issues also became prominent – issues such as religious, patriarchal, capitalism, medical and cultural discourses that had to be addressed.

The boundaries of this research study were defined to exclude women facing an unwanted pregnancy (excluding in the sense of not interviewing these women) and considering an abortion as well as the male partner involved in abortion. However, these boundaries should not be seen as a restriction, but rather as a challenge for future research. Research including the women facing an unwanted pregnancy could for instance address the effect of abortion counselling from a pro-life or a pro-choice stance on the women. As male partners cannot prevent women from having an abortion, a research study with male partners can be conducted as to what the effect of abortion would be on relationships or what the effect of abortion would be on the male partner. Very little literature on male issues and abortion is available in South Africa.

Reflecting on the research topic with its related questions and after processing the research from a literature, research and personal perspective, I came to the conclusion that counselling in any situation is value-laden. With an emotionally intensive subject as abortion, values are even more important. In this sense I experienced that the research topic offered me ample challenges to research and learn about the complexities of abortion counselling and the role of counsellors. I feel content with the formulation, scope and challenges that the research topic presented.

A restriction I experienced whilst doing the research was that statistics regarding ethnic groups and social class were not available from the pro-life and pro-choice organisations, as to reflect on the social class and ethnic group of the women to whom services were rendered at the two different organisations.

### **3. Research methodology**

The research method I used in this research was contemporary feminist ethnography and in particular conceptualising women's behaviour as an expression of social context (Reinharz 1992:53). Looking at women's expression in social context enabled me to understand women's experience from their own point of view. I interviewed women with different stances, specifically female counsellors from pro-life as well as pro-choice stances.

This methodology was effective and appropriate in relation to the research topic as the research study was about female counsellors negotiating their values in abortion counselling. The method I used was a research method "for" woman, used "by" woman and was "about" women (Stacey 1988:22).

The negative side of this research method was that power was not equally distributed between the participants and myself. The reason being that the research participants did not share power from the start of the study. I formulated the research questions and then only requested the interviews with the participants and they graciously invited me. Though I worked in a participatory way while conducting the interviews, total power sharing as suggested by Bishop (1996:168) was limited. In order to stay accountable, I counteracted this power by means of an open invitation to the counsellors that they could at any time have access to the written research study.

Other ways I employed to counteract the power in this research study was by informing the different organisations what the research aims were; obtaining written permission from the counsellors to conduct the interviews and write about the interviews; checking my understanding of the conversations with the counsellors to make sure that my understanding correlated with what they said during the interviews; e-mailing the transcripts of the interviews to the participants and by making sure that what they shared with me was correctly transcribed and in the letter of consent the counsellors were given opportunity to access any part of the research at any time.

I am aware of the fact that I wrote about these counsellors without them having the opportunity to participate in the writing. In order not to misuse or abuse this power position I attempted to stay responsible, accountable and ethical about what I wrote in this research study by being self-reflective and transparent.

In the context of the number of discourses, the number of stakeholders involved in abortion and the complexities of abortion, I feel that the research method offered a flexible yet focused enough framework to research and improve understanding of the research topic.

#### **4. Literature, research and discourses**

Literature indicates that abortion has been practised since 2737-2696 BC (David et al 1988:10). After all these centuries abortion still is, at the beginning of the twenty-first century, a contentious issue. Presently South Africa is experiencing a backlash since the 1996-legalisation of abortion. The abortion controversy is reflected daily in newspaper articles opposing abortion, pro-life riots and in the remarks made by political parties such as the ACDP taking a stance against abortion. On the other hand pro-choice organisations keep on promoting choice to women facing unwanted pregnancies.

Reflecting on the literature I consulted on abortion, it became clear that the legislation of abortion was borne from the desperate need of women. Before legislation, abortion was punishable and resulted in many deaths of women who turned to back-street abortions. Due to legalisation and the introduction of counselling to women requesting abortion, groups such as pro-life and pro-choice became prominent – each group counselling from the stance they firmly believe in.

The literature I consulted added much value to the research study as the literature created awareness to the dominant discourses that played a role in the various perspectives on abortion.

During the research study I became aware of the following discourses: It was the church and especially white males who made decisions about what a woman may or may not do to her body (Trainor 1988:48). It was and in some instances still is the church that decides how women should think about contraception and reproduction. These strategies serve to confirm patriarchy. Another discourse was the influence of capitalism on women's lives. Many women, especially black women, cannot afford abortions and have to continue with the pregnancy or consider other alternatives as back-street abortions, adoption, foster care or taking care of the baby under difficult circumstances.

A discourse was male medical power. Before 1944, women practised midwifery; women had the expert knowledge of pregnancy childbirth and abortion. This knowledge was passed on from woman to woman, sometimes to women in the family or other women who wanted to learn the trade. In South Africa the first female medical doctor registered with the South African Medical Council during 1920. In South Africa midwifery was only legalised in 1945 by means of the Nursing Act No 45 of 1944. By that time white male medical practitioners gained authority over the woman's body, reproduction and childbirth.

The use of language in these discourses became evident during the research study. In the Abortion and Sterilization Act No. 2 of 1975, abortion is being defined as "the abortion of a live foetus of a woman with intent to kill such foetus." The Choice on Termination of Pregnancy Act No. 92 of 1996 uses a different kind of language and describes abortion as "... the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant women." The language used in centralising a specific discourse could also be seen in the use of the term "baby" by the pro-life counsellors while the counsellors at the pro-choice clinic would exclusively use the term "foetus". All these "words" and phrases that are being used, are value-laden and construct a message of "right" or "wrong", depending on the users.

Although the above-mentioned discourses – medical, patriarchal, language, capitalist and racist – play an important role in the abortion debate, none of these discourses has the fundamental influence on abortion of the religious discourse.

During the research study the strong influence of religious discourses became evident. This religious discourse did not only affect counsellors with a pro-life stance but also counsellors with a pro-choice stance. These counsellors have to negotiate their stances and values within the religious discourse created by men and the church. This religious discourse places women and counsellors in a situation where they feel judged by society, the church and God. Even if women should try to use their freedom to make a responsible choice (considering all the options and consequences of an unwanted pregnancy), some still feel burdened by the decision they made. The powerful influence of religious discourses contribute to women feeling judged by God, the church and society.

Although abortion was practised since ancient times, the nineteenth century saw the Roman Catholic Church playing a prominent role in socially constructing abortion as a sinful practice. As a powerful institution, the church shaped the minds of people on abortion and in doing so, influenced the lives of women and counsellors as well as the medical profession. As the body of Christian believers the church has yet to define when life begins. An interpretation on this issue will vary from one denomination to the next. In medical terms life exists when there is a heartbeat and/or brainwaves in a human being. Both of these are present in the foetus at late gestation. The discourse between the church and the medical profession as well as the values of the medical practitioner, complicates the interpretation of "life" in the context of the values of all role players in the abortion debate. However, the debate regarding the beginning of "life" does not address the question of power and knowledge.

With reference to chapter two, the following questions can once again be raised: Who has the power to decide over the body of the woman? Who has the economic and decision-making power regarding abortion? What is said and done, what is not said and not done, centralising specific discourses? Who says it and who benefits?

However, Jantzen (1996a:2) confirms that the question of abortion is much larger than male control of female bodies for sexual and reproductive purposes. She argues: "This control is exercised through the churches, the educational systems, medicine and the state; and the question of abortion can only usefully be considered if one recognizes the pressures placed on women by all of these."

Regarding my understanding of the church, Megan's remark in chapter four, "One should never pass judgement if you're not in the situation...", served as an impetus to move from a more confessional, prescriptive and judgemental position towards a more contextual, caring and participating position.

## **5. Values, ethics and accountability**

During the research study it became clear, regardless of a pro-life or a pro-choice stance, that values, value systems, ethics and accountability were interrelated issues in the abortion debate. These issues affected the client, the counsellor, the medical practitioner and society.

During the interviews with pro-life and pro-choice counsellors, it was clear that personal and professional values and value systems influenced abortion counselling and that value free counselling was impossible. It is not only the counsellor who may face dilemmas regarding abortion but also medical practitioners requested to perform an abortion during a late stage of gestation. The "late stage of gestation" again reflects back to the capitalist discourse and the unavailability of abortion even though it has been legalised in South Africa. My impression is that the abortion dilemma would not be "solved" by means of an exposition of values and moral issues but rather by means of an understanding of discourses such as patriarchy, religion, power and politics surrounding abortion.

The one sure thing about abortion is that the issue is riddled with moral issues. In Eastern countries where more value is placed on males than on females (Weiss 1991), abortion becomes an issue after the sex of the child has been determined. Using live foetuses for medical research purposes (12 reasons 2001) introduces yet another form of moral positioning.

The HIV-Aids epidemic has in its own way influenced the abortion debate. Although it is not a fact that a HIV-positive mother will pass on the virus to her unborn child, the child can be born HIV positive. The latter leads to a short life span with extreme medical costs. This child can also be orphaned or left to be raised by grandparents or family. Regardless the fact if the child will be born HIV-positive or negative, the decision has to be made by the mother, having the right to decide what or what cannot be done to her body. The HIV-Aids issue once again confirms the complexity of the abortion debate.

To my mind the guiding principle through the mire of moral issues would be accountability. The only way counsellors can be accountable during abortion counselling is to respect clients as the experts of their own lives (see chapter three). Respecting their realities and experiential truths will contribute to the counsellors understanding of the dilemma of women facing unwanted pregnancies.

## **6. Research participants**

The participants in this research study included counsellors working from a pro-life and a pro-choice stance. My aim was to establish how they negotiated their own values and value systems in abortion counselling.

### **6.1 Pro-life**

The counsellors at the Pro-Life Clinic were frank and quite enthusiastic to share the work they firmly believed in.

Upon meeting the counsellors I was reminded of the research that Kristin Luker (quoted in Neuger 1995:133) conducted regarding the activists on both sides of the abortion debate:

Luker portrays the average pro-life activist as middle-income, unemployed outside the home, high school educated, married, religious (often Roman Catholic), and with three or more children.

Apart from not being from a Roman Catholic background (and of course not being unemployed), Luker's description fit the counsellors at the Pro-Life Clinic quite well. However, their strong religious commitment and firm belief in the guidance of the Holy Spirit created the context for the work they were doing.

I was really taken by their enthusiasm and the "good work" they were doing. At first I thought what a wonderful way in doing counselling. They were praying for each other, praying for the client, being dependent on the Holy Spirit – the success rate must be phenomenal!

It was only when I started transcribing the conducted interviews that I was left with many unanswered questions. The approach of Pro-Life counsellors was to terminate counselling when the client's values did not correspond with theirs. When the client decided on abortion she would be informed that post-abortion counselling was available after the abortion. I was wondering how ethical it was not to refer a client to an abortion clinic, especially with the potential chaos accompanying an unwanted pregnancy. Was it not during this time that a client needed the counsellor the most? Was the ethical responsibility of the counsellor not in being with the client, helping to make a decision and supporting the client in the implementation of the decision and not withdrawing when it became difficult due to personal beliefs and value systems? I do not imply that the beliefs and value systems of the counsellor are irrelevant or unimportant, but should counsellors not be able to enter the reality of the client without holding on to their own subjective truth (Burr 1995)? Was this not what pastoral care was about – healing, sustaining and growth? I felt almost as if reading Psalm 23:4 in the following way: "Yes, though I walk through the [deep,

sunless] valley of the shadow of death, I will fear and dread evil, for You have left me and await me on the other side of the valley.”

It was only during a follow-up interview with the counsellors at the Pro-Life Clinic that I addressed the ethics of counselling regarding their refusal to refer a client to an abortion clinic. The counsellors admitted that this stance indicated to the client their disapproval of abortion. They felt that they needed to be true to their beliefs about the wrongness and sinfulness of abortion and that this fundamental stance was in no way negotiable. Taking their religious background into consideration (as well as my own Pentecostal background) I could understand that it was of the utmost importance to these counsellors to be true to the Word of God and what they believed was the truth. I realised that having a confessional approach could contribute to moral prescriptions outside of the real situation. Applying this approach contributed to the marginalisation as well as abusive attitudes towards people. Ethically, if we participate in the decision making process, we have to be present at the most important time, when it is about doing and not merely talking.

Reflecting on contextual theology, would referring and even accompanying a client to an abortion clinic be a way in conveying God's care? Even though one of the Pro-Life counsellors claimed that she could understand why some women decide on abortion, she would in no way become part of the decision. She had to remain true to what she believed God's opinion of abortion was: wrong and a sin.

### **Negotiating values**

It was clear that these counsellors negotiated their values and belief systems about their perceived wrongfulness of abortion through the fact that they supplied the client with all the information they could regarding the choices of dealing with an unwanted pregnancy. They would offer all the support they could, given the client decided on alternatives such as adoption, foster care or single parenting. However, should the client insist on an abortion, support was only available in the form of post-abortion counselling. The client would not be referred to an abortion clinic, supplied with a contact number or name of a person at an abortion clinic or offered emotional support.

I would again like to refer to, Carlson and Erickson (1999:62) as described in chapter three:

When we hold certain clearly defined values that are personally significant and then do not act on those values in therapy we may experience a moral dilemma. Melton (1968) described this moral dilemmas 'value schizophrenia.' He uses the word schizophrenia to highlight the splitting of personal values form the values that are expressed in therapy.

I was wondering if the Pro-Life counsellors were not experiencing "value schizophrenia" in the sense that they do not refer clients to an abortion clinic, but they are willing to do post-abortion counselling. During the post-abortion counselling the counselling is done from the value perspective of the counsellor, which can again be abusive to the client.

It was clear, and confirmed by the counsellors, that they negotiated their values, value systems, with themselves, their preferred values and religious beliefs, with the Other/other, their supervisors and counselees through their belief that abortion was the client's own decision and responsibility and that the client needed to carry the consequences of the decision.

The counsellors did believe in the forgiveness of God. Forgiveness in the sense that, when a client would repent and ask forgiveness for the abortion, God would forgive her. Forgiveness in negotiating values also played an important role in the lives of the counsellors in the sense that they would ask God's forgiveness if they had not used the opportunity to convey truth to the client. Truth (as discussed in chapter four implied that it was white males that decided about what was labelled as sin and what not) meant to them that abortion was a sinful and immoral practice.

The pro-life counsellors I interviewed were driven by religious values. The reason they are were with Pro-Life was because they believed in the religious views of the institution that coincided with their own value systems. The question was whether clients knew that when they approached Pro-Life for assistance? Were they only to realise that after a number of counselling sessions? This issue has not been researched. The ethical accountability of these counsellors could be challenged in this instance. Pro-Life was providing a service to people in need, but they performed the service on the basis of their values and tried to steer the client towards their preferred values and expected outcomes.

The discourse between ethics and the availability of a biased counselling service in itself is a complicated situation to negotiate. Pro-life counsellors find themselves caught up in this discourse. These counsellors are true to their own realities and the "one objective truth" they believe should be conveyed to their clients.

## **6.2 Pro-choice**

I remember my phone call to the Pro-Choice Clinic to confirm my appointment for the Wednesday. The director asked me to postpone the appointment because they were seeing twenty clients on that particular Wednesday.

I felt upset and confused and all I could think of was twenty abortions being done on one day! Murder, sin, pain, shame, life long guilt, self-blame, a process of repentance, forgiveness, healing and carrying own responsibility? Was that the devil's way of burdening women for the rest of their lives? What did God think about abortions taking place? And the counsellors, how could they live with themselves conducting these abortions? My religious background was crying out. That thought once again confirmed my own fundamentalist stance and believes regarding abortion.

Eventually I had the opportunity to interview the three counsellors at the Pro-Choice Clinic. At first I was surprised and amazed to hear about their calling to do this work. Reflecting on my "amazement" I realised that I held the belief that abortion was a sin and could not bargain on any religious blessing or calling from the Holy Spirit.

It is necessary to state that these counsellors are black and describe themselves as Christians. They understand their clients requesting abortions because they are familiar with the circumstances of these women. Schoombie (1999:68) confirms in her research that reasons for abortion amongst black women are rape, financial reasons, continuation of studies and deteriorating relationships.

Kristen Luker (quoted in Neuger 1995:133) highlights the understanding of women's experiences from their own point of view as well as the conceptualisation of their behaviour as an expression of social context:

The pro-choice woman knows that mothering, especially unplanned mothering, may destroy her economic and employment security and leave her vulnerable to sex discrimination in the workplace.

Luker (Neuger 1995:133) emphasises the situation of economic disempowerment women still find themselves in. Many black domestic workers do not have any medical aid and their contracts do not provide for maternity leave. A pregnancy could mean losing their jobs, confirming Schoombie's (1999) research.

### **Negotiating values**

Although these counsellors understand the circumstances of the women requesting abortions, it does not imply that they are not facing their own dilemmas about abortion. The way they negotiate their values and value systems of abortion counselling is through the unquestionable belief of God's forgiveness. I learned from these counsellors that society and the church were judging abortion severely while "other sins" were overlooked.

These counsellors are aware of the fact that an abortion decision is not an easy one. This sensitises them to be aware of any hesitation or uncertainty a woman experiences arriving at the clinic. Never did I get the impression that these counsellors misuse their power in any way to talk a woman into or out of an abortion.

This is not to say that those choices will be ideal or without regrets. It is normative to experience both ambivalence and sadness in any decision about an unplanned or unwanted pregnancy. Experiencing ambivalence and distress does not indicate a poor choice. It only indicates the need to tolerate the ambiguity of being human in a world that calls for us to try to use our freedom responsibly.

(Neuger 1995:140)

Pro-Choice counsellors are more understanding towards women requesting abortion in cases of rape, incest and abnormalities of a foetus. I came under the impression that the pro-choice counsellors were less trapped in the idea of conveying their own values to their clients. This could be because they positively accepted abortion, though they confirmed that they were not pro-abortion, but pro-choice. The "choice" was primarily that of the woman facing the unwanted pregnancy. The "choices" of the other role players such as the parents and male partners, were negotiated via the interaction with the women facing the unwanted pregnancy. The parents and male partners were made aware of the values of Pro-Choice that the choice should be made by the woman facing the unwanted pregnancy and not by the parents or male partner.

## **7. The women facing an unwanted pregnancy**

For the purpose of this research study specific focus on the experiences of women facing unwanted pregnancies were excluded. The reason being that my curiosity was mainly about the ways in which counsellors negotiate their values during abortion counselling. Should the study include the client as well as the counsellors, the scope would have been too wide to be accommodated in a master's dissertation. However, I was not insensitive to the voices of these women during the research study. I was aware of the fact that much research in South Africa needed to be done on abortion counselling and the effects on men and women who are touched by abortion.

Though the research study did not include the social context of woman facing an unwanted pregnancy it was a voice that made it self heard throughout.

Being a white, middle class South African woman with a regular income and a supportive husband, it was very easy for me to take a pro-life stance. Not thinking about the circumstances of other woman could lead me to support the counselling that the pro-life counsellors were doing. Until I spoke to the black pro-choice counsellors who had first hand knowledge of their sisters' circumstances.

[W]e must understand the issue of reproduction in larger terms than conception, pregnancy, and birth. Reproducing ourselves involves long-term commitments to provide care and support to those we bring into being. Those who are responsible for that care must be able to have the clearest voice making careful decisions about reproduction.

(Neuger 1995:139)

Neuger (1995:139) implies that an abortion decision is not a simple choice about right or wrong, or about a counsellor or a client's value systems. It is a choice that is influenced by responsibility towards a long-term commitment should the women decide to continue with the pregnancy. History confirms that it was usually "poor women and women of colour [who] were the ones who suffered as a result of abortion restrictions" (Neuger 1992:129).

This also reflects the stance of Anderson and Goolishian (1992:28) that clients are the experts of their own lives because they have the local knowledge of their own life circumstances. With reference to the abortion debate, this expert knowledge the client owns will afford the client the right to choose either for or against abortion. Out of the pastoral counselling position we rather need to empower women's voices than to participate in discourses promoting patriarchy that silences women.

I realised that this research study left me with a responsibility towards the client as I asked myself the following questions: "To what extent is the client accommodated and really helped during abortion counselling?", "What is the effect of counselling, be it from a pro-choice or a pro-life stance on the client receiving counselling?" and "Could the way in which abortion counselling is done be harmful to the client; could the client be treated in an ethical way during the counselling process?"

## **8. Self-reflection**

It was only after conducting the interviews with the pro-choice counsellors that I realised that the research study and the research process was busy challenging my ideas and beliefs about the abortion debate.

During the research process I personally experienced a tremendous amount of conflicting emotions and dilemmas and realised that I was also in a negotiating process regarding my values and beliefs and that I was busy negotiating an own position in the abortion debate.

I remember my interaction with the pro-life counsellors, understanding their passion to be instruments in the hand of the Lord to bring about healing in women's lives through the working of the Holy Spirit. My own Pentecostal background made me to understand the inner healing process that they practised during the

post-abortion counselling. It was only after reflecting on this specific interview that my own inner conflict about this counselling process started. I could understand, looking at counsellors in social context, that these counsellors were practising within their own social context as well as the social context of the church that supported a pro-life stance. This prompted me to start thinking about the effect of this counselling on the women on the receiving side.

I started wondering particularly about the post-abortion facilitation process in which the women had to fill out a questionnaire where imagery assists her to return to the day of the abortion. She is taken through the whole process to examine her behaviour of denial and the methods she uses to cope with the abortion. She also needs to fill out a checklist to determine whether she suffers from depression and needs to be referred to a psychologist. During the facilitation process the client needs to deal with feelings of guilt and shame that (according to the pro-life counsellor) usually accompanies abortion. I was wondering if this whole process did not re-traumatise the client and from a narrative pastoral viewpoint whether this was not in contrast to what I would term pastoral or mutual care.

According to the pro-life counsellor the fifth session in the post-abortion counselling was the most important. She described that session as the turning point in the client's life. The client had the opportunity to mourn the loss of her baby. This session included prayer to obtain a vision of the Lord regarding the sex of the baby and how the baby or child would have looked (sometimes the abortion took place years ago). The woman had the opportunity to choose an object for example a precious stone, to symbolise the tombstone for the baby and to have something tangible to remember the baby by. This session also included the name giving of the baby.

The sixth session dealt with the woman's responsibility. She needed to realise that the abortion was her own decision, not her boyfriend's, husband's, mother's or doctor's decision.

Reflecting on the above-mentioned practice, the implied message to the client was that *she* was responsible for the "sin" she had committed. With reference to chapter four, sin was discussed as to whom decided what sin was. In no way was it conveyed to her that she did not have freedom of choice and that she acted in a responsible or caring way regarding the choices she had. This made me realise that the way in which Pro-Life counsellors counselled, was situated in a religious discourse of sin, repentance and forgiveness.

Embedded in this discourse was the language that was used by these counsellors. Though they would not use the word "murder" during abortion counselling, they referred to abortion as a sin and use the word "baby" to make the woman understand that she was carrying life and a human soul. "From a pastoral perspective

there is a dire need for alternative understandings of suffering within the Christian tradition" (Tatman 1996:221). From a feminist theological perspective a woman need not suffer because of her perceived sin – when suffering is a result of discourses it is the responsibility of the counsellor to make the voices of the marginalised and oppressed heard.

Reflecting on the use of the word "murder", I realised that these counsellors do not use the word "murder" towards their clients. I was wondering if this was indeed ethical feeling so strongly about abortion describing it as "murder" and not mentioning it to the client or not using the same language in the counselling session.. Again using the word "murder" would ethically imply that one would do anything to prevent a murder from taking place.

The eight counselling session dealt with forgiveness. The client needed to forgive the people towards whom she had feelings of anger, for example the doctor, boyfriend, husband, mother and herself. The last session of the post-abortion counselling included the acceptance of the loss caused by the abortion as well as the consequences the woman suffered. This session also included remembrance of the baby for example the day the abortion took place.

Looking back on the social construction of abortion and the connotation that it was considered a sin and even defined by some as murder – instigated by men in positions of power ("man-made") and religious and medical discourses – I came to the realisation that as counsellors and society we were burdening and even victimising women who were pro-choice, with unnecessary feelings of guilt and shame.

It also bothered me that a "recipe" was being followed in post-abortion counselling. If a client were considered the expert of his or her own life, would this recipe fit all women who had abortions? This contradicted the notion of the client as the expert of his or her own life. My impression was that Pro-Life counsellors felt obliged to convey the "truth" about abortion to their client.

Reflecting on practical pastoral counselling that includes being able to counsel regardless of social class, race, gender or denomination, I deemed the way in which these counsellors worked as restrictive and punitive. If counsellors are not open to the fact that a client's religious beliefs might differ from theirs, the help they offer could be very restrictive and punitive. This is confirmed by the way in which Pro-Life counsellors did post-abortion counselling.

It was after conducting the interviews with the Pro-Choice counsellors that I started wondering about women's individual experiences and finding their own ways of making sense of the chaos that an unwanted

pregnancy created in their lives. Although I do respect the participant's values and beliefs, it does not blind me to become aware of dominant discourses such as religion and fundamentalism in their practices and their ignorance of these discourses.

It was through the awareness of the dominant discourses that I realised that this research study left me with a responsibility towards the counselling profession to be more aware of the effect counselling has on people consulting me. These effects will only be known when a research study is conducted consulting the women on the receiving end of the counselling. This implies that counsellors need to be aware of the effect of the following: adoption, foster care, single parenting and abortion.

While conducting this research my stance and views about abortion and abortion counselling were constantly challenged. I became aware of the fact that I have participated in the dominant punitive discourse of religion. It was the words of a pro-choice abortion counsellor that made me realise that I was trapped in the "taken for granted knowledge" (Burr 1995) of abortion as "wrong". This counsellor's words were: "I don't know what God's opinion is about abortion." Reflecting on this remark, I realised that no one knows for sure what God's opinion was. We could speculate about this, interpret the Bible, believe that we have the guidance of the Holy Spirit, but as each person has her own reality whereby she constructs her own life, I realised that no one rule could be laid down by which abortion counselling should be done.

I realised that there was other things about God, according to the Bible, that we could know for certain: that he is merciful, that he forgives us and that He cares for us and that He wants us to love our neighbour as ourselves. To me this implies that He would also understand that all circumstances in which an unwanted or unplanned pregnancy takes place are not ideal. Deciding on an abortion in unpleasant life circumstances urges me to rely on God's understanding and caring for us as human beings and not thinking of Him as a God waiting to judge and punish us.

In concluding the research I felt left with a responsibility towards the client as well as a responsibility toward the counselling profession. With reference to chapter three, as pastoral counsellor I want to stay well informed about all the aspects of abortion in order to render an efficient service to women seeking abortion counselling, understanding that abortion is not an isolated issue, but an issue with many dynamics. The responsibility of the narrative pastoral counsellor lies within giving a voice to the voiceless women or those who is and has been marginalised by the abortion debate. "Feminist theologians are calling everyone to be accountable both for their personal actions and their actions *as members of social, political, economic and religious groups*. Part of the process of accountability involves acknowledging one's complicity in the perpetuation of systemic sins and evils" (Tatman 1996a:218).

Reflecting on contemporary feminist ethnography, a research method for woman, by woman and about women (Stacey 1988:22), states that one of the negative aspects of this research method could be exploitation of participants (Enslin 1994:545). If I had in any way exploited any participant, I do apologise. This same research study, however, left me, the researcher with the responsibility to ask the question: "What value did this research add to the lives of women?" Or as Enslin (1994:545) states, "which women benefit from the knowledge of women's words?" Reflecting on this question I realised that there was no straightforward answer. The knowledge I gained from the Pro-life and Pro-choice counsellors should be shared with fellow counsellors with the aim to create awareness that abortion is not an issue only consisting of values and morals, but about personal circumstances, culture, choices and discourses that influence the abortion choices.

I want to share the knowledge I gained from this research with fellow counsellors – taking responsibility for how we co-construct the lives of our clients. The challenge for future research lies in challenging ethical and unethical practices in collaboration and participation with research participants.

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**ANNEXURE A**

Institute for therapeutic  
development  
instituut vir terapeutiese  
ontwikkeling



P.O. Box 35214 Menlo Park 0102, South Africa  
Tel / Fax: (012) 460 6704  
E-Mail: [itd@cybertrade.co.za](mailto:itd@cybertrade.co.za)

20 July 2001

The Director

Pretoria

Dear Ms

Louisa van Vuuren is currently doing her MTh degree in pastoral counselling at Unisa through ITD. As part of the degree she has to do a research project under supervision of Dr Elmarie Kotzé and myself. Her research project will focus on abortion counsellors' ways of negotiating values in the counselling process. A more detailed research proposal is attached.

We would be grateful if you can grant Louisa permission to interview some of your counsellors. As it is of utmost importance for us that the counsellors themselves as well as your clinic and patients should benefit from the research, we will do all we can to ensure that your needs are met during and after the research interviews.

With kind regards

Prof DJ Kotzé

Director: ITD

## **ANNEXURE B**

### **NEGOTIATING VALUES IN ABORTION COUNSELLING**

#### **Introduction**

A research project is being undertaken as part of the requirements for a Masters degree in Practical Theology – with specialisation in Pastoral Therapy. The research project is about the value challenges counsellors experience when counselling women with unwanted pregnancies and part of this research requires that a number of counsellors be interviewed on the mentioned subject.

The purpose of this memorandum is to obtain approval to conduct these interviews with at least three counsellors in your organisation.

#### **The aim of the research project**

The aim of the research project is to find the answer to the following research question:

*“What value challenges do abortion counsellors experience, what ways have they found in negotiating these challenges?”*

In order to answer the above mentioned research question, the following questions need to be asked:

- Which value challenges do you experience as a counsellor?
- How do you negotiate these challenges with your-:
  - ✓ Self
  - ✓ Values
  - ✓ Religious beliefs
  - ✓ O/other
  - ✓ Supervisors, and
  - ✓ Clients

## **Method of Research**

During this research project, Contemporary Feminist Ethnography research methodology will be used. This research methodology has three goals:

- To document the lives and activities of women,
- To understand the experience of women from their own point of view, and
- To conceptualise women's behaviour as an expression of social context.

## **Participants needed for the study**

Three counsellors of the Pro-Life Clinic need to be interviewed, telling about their challenges as counsellors in an abortion clinic.

## **What will be required of participants?**

Should you agree to take part in this project, you will be asked to give consent for the information obtained during the interview to be used in the research project.

Two interviews with each counsellor are needed with a time span of approximately one month between the first and the second interview. The course of one interview will approximately be one hour per counsellor.

If permission is granted from the counsellor, notes will be taken down during the interview.

## **Free participation**

You are free to withdraw from the research project at any time without any consequences to your.

## **Results of the study**

The results of this project may be published. At your request, names will be distorted to ensure your anonymity. You will have the choice to use your own name or a pseudonym of your own choice.

You are most welcome to request a copy of the research results should you wish to.

## Questions of participants

Should you have any questions or concerns regarding the project, either now or in the future, please feel free to contact me:

Louisa van Vuuren

Tel: (012) 307 4616

Cell: 082 679 3903

Or my supervisor Dr E Kotzé (D Litt et Phil) at the Institute for Therapeutic Development

Tel: (012) 460 6704

This project has been reviewed and approved by the Institute for Therapeutic Development.

## Request

Approval is hereby requested to interview at least three counsellors of your organisation regarding their experience and values when counselling women with unwanted pregnancies.

Student: CJL Janse van Vuuren

---

Supervisor: Dr E Kotzé

---

Approved

Director: Pro Choice Clinic

---

## **ANNEXURE C**

### **NEGOTIATING VALUES IN ABORTION COUNSELLING**

#### **Introduction**

A research project is being undertaken as part of the requirements for a Masters degree in Practical Theology – with specialisation in Pastoral Therapy. The research project is about the value challenges counsellors experience when counselling women with unwanted pregnancies and part of this research requires that a number of counsellors be interviewed on the mentioned subject.

The purpose of this memorandum is to obtain approval to conduct these interviews with at least three counsellors in your organisation.

#### **The aim of the research project**

The aim of the research project is to find the answer to the following research question:

*"What value challenges do abortion counsellors experience, what ways have they found in negotiating these challenges?"*

In order to answer the above mentioned research question, the following questions need to be asked:

- Which value challenges do you experience as a counsellor?
- How do you negotiate these challenges with your-:
  - ✓ Self
  - ✓ Values
  - ✓ Religious beliefs
  - ✓ O/other
  - ✓ Supervisors, and
  - ✓ Clients

## **Method of Research**

During this research project, Contemporary Feminist Ethnography research methodology will be used. This research methodology has three goals:

- To document the lives and activities of women,
- To understand the experience of women from their own point of view, and
- To conceptualise women's behaviour as an expression of social context.

## **Participants needed for the study**

Three counsellors of the Pro-Life Clinic need to be interviewed, telling about their challenges as counsellors in an abortion clinic.

## **What will be required of participants?**

Should you agree to take part in this project, you will be asked to give consent for the information obtained during the interview to be used in the research project.

Two interviews with each counsellor are needed with a time span of approximately one month between the first and the second interview. The course of one interview will approximately be one hour per counsellor.

If permission is granted from the counsellor, notes will be taken down during the interview.

## **Free participation**

You are free to withdraw from the research project at any time without any consequences to your.

## **Results of the study**

The results of this project may be published. At your request, names will be distorted to ensure your anonymity. You will have the choice to use your own name or a pseudonym of your own choice.

You are most welcome to request a copy of the research results should you wish to.

## Questions of participants

Should you have any questions or concerns regarding the project, either now or in the future, please feel free to contact me:

Louisa van Vuuren

Tel: (012) 307 4616

Cell: 082 679 3903

Or my supervisor Dr E Kotzé (D Litt et Phil) at the Institute for Therapeutic Development

Tel: (012) 460 6704

This project has been reviewed and approved by the Institute for Therapeutic Development.

## Request

Approval is hereby requested to interview at least three counsellors of your organisation regarding their experience and values when counselling women with unwanted pregnancies.

Student: CJL Janse van Vuuren

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Supervisor: Dr E Kotzé

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Approved

Director: Pro Life Clinic

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## **ANNEXURE D**

### **NEGOTIATING VALUES IN ABORTION COUNSELLING**

#### **CONSENT FORM FOR PARTICIPATION BY COUNSELLORS**

I have read the Information Sheet concerning the project and I understand what the project is all about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the research project is entirely voluntary.
2. I will receive no payment or compensation for participating in the study.
3. I am free to withdraw from the interviews at any time without any disadvantage.
4. I give permission for the information obtained during the interview to be used in the research report.

I am willing to participate in this research project.

\_\_\_\_\_  
(Signature of participant)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Name of participant in capital letters)

\_\_\_\_\_  
(Signature of witness)

## ANNEXURE E

### Dear fellow counsellors

Thank you for the time you spent with me to discuss your particular challenging counselling practice. This letter is a short summary of what we have discussed. If you have the time to read or even to respond to this letter, I would appreciate it. If not, I thank you for the time spent with me and for assisting me in my research.

I became aware that you all had personal experiences that, as you said, "prepared" you for the work at the Pro-Choice Clinic. Sandra and Mary-Ann shared with me that they had difficulty conceiving while Sandra suffered a miscarriage during her twelfth week of her first pregnancy. Although these were painful experiences, you were able to look back and "see the hand of the Lord" in preparing you for the work at the centre. Mary-Ann's passion for children and her "desert experience" with the Lord during the time she had difficulty conceiving paved the way for her involvement at the centre. Nora shared with me that she used to live close to the centre and every time she passed, she had the urge to become part of the centre. It was only after reading *The Atonement Child* by Francine Rivers that Nora experienced an intense calling from God to become involved at the centre.

You mentioned the qualities that you think a counsellor needs to do abortion counselling. I list a few:

- To create a safe situation for your client;
- Being dependent on the Holy Spirit;
- Being in a strong spiritual relationship with the Lord;
- To know that you need the wisdom of the Lord to lead you through the counselling session with your client;
- Love and compassion for healing to happen (grace and truth);
- To have compassion, empathy, sympathy, humanness and warmth towards your client;
- To be non-judgemental and non-critical towards your client, even if it is the third or fourth abortion;
- Being able to put yourself in your clients shoes;
- To be genuine and "unshockable" when you hear painful information.

You all emphasised that the calling to do counselling was the reason for your involvement at the centre. You told me that you depended heavily on the guidance of the Holy Spirit. You started your counselling sessions with prayer and would also intercede for each other during a counselling session or would ask your fellow counsellors to pray for the client whose pregnancy test is was positive and who need to make a

decision about her future. I understood that when you felt lead by the Holy Spirit to pray for a client, you would only do that if the client agreed.

Would you say that you were striving to bear the fruit of the Holy Spirit as being described in Galatians 5:21? Or were there other guidelines that you deemed important? Would you prefer people requesting counselling to recognise these in you? How would you know that they recognise these in you? Were you sometimes asking their opinion about these?

You talked to me about the strong "feeling of belonging" amongst you all. Would you call it group cohesion, care for one another or the love of the Lord binding you together? You talked about how praying together strengthened you in your work.

I was wondering how you viewed the supervision that you received and if that was something that we could discuss when I see you next time? Did you feel the supervision sessions were helping you to strengthen you in your views that abortion was wrong and a sin or to help you to keep a non-judgemental stance towards a client who did not share your frame of reference? Did you feel that supervision and de-briefing with each other would prevent you from being heavily overburdened by the pain and circumstances of other women?

I asked you to recall and tell me about something special that you experienced during your involvement at the centre – a "sparkling moment" that stood out for you.

Nora recalled the day she started working at the centre and confirmed that **that** was her sparkling moment. Nora, I could really "see" the enthusiasm and excitement that you experienced. I could see that the counselling meant a lot to you and perhaps it was this enthusiasm that confirmed your calling for the post-abortion counselling the Lord was leading you into.

Sandra recalled her counselling with a woman who had a therapeutic abortion due to the diagnosis of Down's syndrome. This woman's decision about the possibility of a future "Down's syndrome pregnancy" was that she would do it again. When this woman fell pregnant she requested Sandra to pray for her. When the results of the amniocentesis came, no abnormalities were detected. Sandra, this was your sparkling moment, the fact that you read this as the Lord answering your prayers. To you this was also the confirmation of your calling.

Sandra I was wondering, should the amniocentesis again have confirmed Down's syndrome, how would you have made sense of the diagnosis? How would you have consoled the mother and how would you have managed to come to terms with your own disappointment? How would you have talked to God in those circumstances? If these questions are unfair, I apologise. Please ignore the questions if you feel that I am imposing on your personal relationship with God or your beliefs.

I was asking these questions because I sensed that counsellors could experience difficulty with their own emotional feelings when a woman was contemplating or having a second or third abortion. I was wondering whether the fact that you experienced your counselling as a calling would be able to sustain you in such a difficult situation?

Mary-Ann recalled her sparkling moment as being part of an adoption ceremony. It was about a client who did not want to undergo an abortion, though her boyfriend suggested it. Mary-Ann referred the client to House Esther where she could go through the process of having her baby adopted and choosing the adopting parents. Though you said you only played a very small part in the whole process, this was a very special moment for you. I recall Mary-Ann saying that giving up a child for adoption "is the most unselfish thing a woman could do".

When I heard the story Mary-Ann told, I realised that I did not ask you questions about the women who gave up their babies for adoption. I was wondering if it was appropriate to ask you about this? Was this something that we could discuss during our next session?

Thinking of a woman giving up her baby for adoption, many questioned came to mind. Were the biological mother to be present when we talked about the adoption, what would you think she would have said? Would she have said that she was thankful that the baby received good parents; would she have said that she was scared that the baby would lose contact with the African culture and tradition in a foreign country when the adoptive parents were living outside South Africa? Would she have said that she should never have given up her baby for adoption? Or would she have said something totally different? Have you experienced women returning to the centre with remorse or guilt or even blaming God or religious ideas that "forced" them to give up their babies for adoption?

Some literature would describe the women giving up their babies for adoption as having to take a "background role" when it came to the adoption process, almost a "silenced voice" or even a voiceless participant. How would you see the situation – especially if you would hear their views about themselves? Have any of you asked them for reflections on the adoption process after it had been finalised? Would you

be willing to share this with me if you have any information? Would you say that the women viewed themselves as persons providing a gift to someone else, or as helpless and voiceless because of circumstances? Have you at times encountered personal anger and pain because of their pain, emptiness, loss, confusion, blame or pressure?

From your conversations with them, would they experience the choice as "no choice at all"? Could they experience themselves as being marginalised and silenced or even blamed for the situation? Would they talk about experiencing guilt and an inability to continue with an abortion even though the reality of an abortion was also very painful? Would they sometimes exchange one kind of guilt for another?

Have you developed any ideas of how they view religion and spirituality? Would they speak of resentment and anger because they viewed religion as oppressive, punitive and restrictive or would they talk about religion as an answer, supportive and understanding to their situation?

This also made me think of my own religion and spirituality during counselling. I was wondering about what spirituality I favoured and how these ideas informed and formed my practice? This got me reflecting about how a person's (who consults me) spiritual talk challenged or resonated with my own spiritual talk as a counsellor? I was wondering if I would be receptive enough to be challenged on some of my fixed ideas?

Have you ever experienced restrictive or punitive God-talk to have a painful effect on a client? Have you come across any dominant religious ideas that we, as counsellors, hold that would restrict or close down our listening to clients' spiritual talk because it would not fit with our frame of reference? If so, how would you counteract these?

Would you think that counselling is more emotionally taxing and difficult when we have definite and valued ideas, moral beliefs and principles regarding our own spiritual beliefs? What made me wonder about this was a comment by a fellow counsellor who said: "I don't know what God's opinion is about abortion." I was wondering if you could recall instances when you thought God would be able to "understand" the circumstances for an abortion?

In light of the above-mentioned dilemmas, I was wondering if a totally non-judgmental attitude towards a client was at all possible? If I have a pro-life or a pro-choice stance, or even if I should try to be neutral, in what way would the client be able to pick up my stance and what effect would my reciprocity have on the client?