PSYCHOLOGICAL EFFECTS OF THE TERMINATION OF PREGNANCY BY CHOICE ON ADOLESCENTS

by

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submitted in accordance with the requirements for the degree of

MASTER OF ARTS

in the subject

NURSING SCIENCE

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF GB THUPAYAGALE-TSHWENEAGAE

NOVEMBER 2014-
DECLARATION

I declare that PSYCHOLOGICAL EFFECTS OF THE TERMINATION OF PREGNANCY BY CHOICE ON ADOLESCENTS is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE
(Mrs BR Sebola)

DATE
The aim of this study was to explore the psychological effects of termination of pregnancy by choice amongst adolescents within the ages of 18 to 21 years.

Exploratory, contextual, qualitative design was used to determine the psychological effects of termination of pregnancy by choice amongst adolescents. Purposive sampling method as well as snowballing were used to select participants for the study.

Data collection was done through in-depth, one-on-one, face-to-face interviews, using a semi-structured interview guide.

The study highlighted that adolescents who seek abortion are unmarried and mostly still studying.

The results revealed that adolescents experience mental ill health after termination of pregnancy due to feelings of guilt. All participants stated that abortion is murder of a life person and that it is a bad thing to do.

The study revealed that counselling that is done before TOP focuses on the procedure of TOP. There is need for a holistic approach to counselling.

As a guide, policy makers need to specify the mandatory counselling in the Choice on Termination of Pregnancy Act (Act No 92 of 1996).

**KEY CONCEPTS**

Adolescent; termination of pregnancy by choice; psychological effects.
ACKNOWLEDGEMENTS

I give thanks to God my father, for the privilege He afforded me to do this study.

I acknowledge the following persons:

- My husband Johannes, my children Tshego, Kgomotso, Khumo, Motlodiwa, Tshepo, Ikgalaletse, Motlotleng, Ofilwe, Kganya and Ayanda, for encouragement.

- My supervisor, Prof Gloria Thupayagale-Tshweneagae, who had my welfare at heart, throughout this journey.

- My friends and study partners, for encouragement.

- Rina Coetzer, for formatting the dissertation.

- Professor S Modesto, for editing this work.

- The ladies who shared their stories with me. God bless you.
Dedication

I dedicate this study to all the adolescents who dared reveal their stories about the termination of their pregnancies to me, and to those who will read this study.

May God keep you
# CHAPTER 1

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LIST OF ABBREVIATIONS

CTOP  Choice on Termination of Pregnancy
CTPA  Choice on Termination of Pregnancy Act
PTSD  Posttraumatic Stress Disorder
TOP   Termination of Pregnancy
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Annexure A

Approval from the Research and Ethics Committee, Department of Health Studies

UNIVERSITY OF SOUTH AFRICA Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

Date: 20 November 2013  Student No: 294-191-0

Project Title: Psychological effects of termination of pregnancy by choice on adolescents.

Researcher: Botshelo Rachel Sebofa

Degree: Masters in Public Health

Supervisor: Prof GB Thupayagale-Tshweneagae

Qualification: D Tech

Joint Supervisor:

DECISION OF COMMITTEE

Approved  Conditionally Approved

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON; DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

PRETORIA
Annexure B

Request for permission to do research
Annexure B

Request for permission to do research

The Chief Executive Officer
Kalafong Hospital
Private Bag X396
Pretoria
0001

Dear Sir/Madam

My name is Botshelo Rachel Sebola.

I am currently studying MA Public Health with the University of South Africa.

I hereby kindly request permission to make use of records of clients who underwent termination of pregnancy at your TOP clinic. These records will be used for recruitment of participants by tracing all adolescent clients who terminated pregnancy at your institution. Informed consent from each potential participant will be obtained before their participation. All the documents used for data collection will ensure anonymity and the information collected from participants will be treated confidentially. The results of this survey will be published so that service in this field could be improved. This information will also be made available to your institution. The research proposal has already been approved by the University of South Africa. A copy of the document of approval is attached for your attention.

Hoping that this request will be favourably considered.

I thank you in advance.

Yours faithfully

BR Sebola

Contact number: 0798200125
May God keep you.
CHAPTER 1

INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Unwanted pregnancy is the major cause for choice of termination of pregnancy for many adolescents. It is also the leading cause of maternal morbidity and mortality in the world (Guttmacher Institute 2012:35).

Adolescents (15 years to 19 years) are more susceptible to unwanted pregnancies, due to premarital sexual activity which is reported to be on the rise in most parts of the world (Ely, Flahetry & Cuddeback 2010:272). According to Hlalele (2008:10), more than fifteen million adolescents aged between 15 to 19 years give birth every year and five million of the same age cohort terminate pregnancy every year (Hlalele 2008:10). There is no study known to the researcher that concentrated solely among the late adolescents 18 to 21 years, which is the focus of this study.

Termination of pregnancy (TOP) in South Africa was legalised in 1997 (Seepe 2001:1). In 2001, there were 155 624 cases of legalised termination of pregnancy. More than half the number, 80 373, were adolescent girls under the age of 18 years. Adolescent abortion or termination of pregnancy by choice has been linked to a number of physical and psychological problems, including suicide attempts or suicidal ideation (Blum & Nelson-MMari 2004:402). The problems linked to termination of pregnancy by adolescents are related to the difficulties associated with reproductive decision-making, which is reported to be not easy even for older mature and married women (Butler 1996:397) as cited in Hlalele (2008).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

MCConnel (2008:1) reports that more than four in ten adolescent girls get pregnant before the age of 20. There are more than 500,000 live births annually among the 15-19 year olds in the United States of America for instance, and 100 000 pregnancies
among the same age group in South Africa (Seepe 2001:1). An estimated 50% of these adolescents would end up terminating unwanted pregnancies. The current media reports have also given very depressing statistics of girls as young as 13 years old getting pregnant (Sowetan 2013, Monday, 15th October).

According to Mpshe, Gmeiner and Van Wyk (2002:69), the promulgation of the Choice on Termination of Pregnancy Act (Act 92 of 1996) was viewed as a saving grace for unwanted pregnancies among women especially adolescents. However, the number of terminated pregnancies is increasing at the rate at which pregnancies are occurring (Tlale 2010:29). Studies need to be carried out which would ascertain any psychological effects after termination of pregnancy.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The emotional turmoil associated with the decision to terminate pregnancy has been researched among adult women (Mycoyd 2007:17; Koeronrop 2005:34). However, very little research has been done on termination of pregnancy by choice among adolescent girls. In South Africa, TOP is done amongst all age groups of adolescents (Boezart 2010:24). Termination of pregnancy may be a spur of the moment decision but the consequences may be negative. The researcher in her workplace has observed that most adolescents who had terminated pregnancy by choice frequent the clinics with somatic ailments such as headaches, and bouts of anxiety. This observation has then motivated the researcher to embark on the study. In addition, there is very little research in South Africa known to the researcher, on the psychological impact of abortion amongst adolescents, 18 to 21 years of age. The purpose of this study is to bridge this knowledge gap.

The question of whether termination of pregnancy causes psychological harm continues to be debated today. Morris and Orr (2007:711) state that research in this area is made difficult by low participation rates, large drop-out, large numbers of confounders, large variety of potential outcome factors and potential influence of the political and social environment on results.
Several authors state that women and teenagers’ reaction to abortion is influenced by their reasons for aborting (Ehrlich 2006:17), the highly complex and sensitive decision-making process related to abortion (Hlalele 2008:10) as well as age (APA Task Force Report 2009).

1.4 DEFINITIONS OF KEY CONCEPTS

1.4.1 Psychological effects

According to Hornby (2005:1172) the term psychological implies “connected to the mind” and the term ‘effect’ means a change that something causes in something else or a result (Hornby 2005:465). Psychological effects of CTOP on adolescents are therefore mental changes caused by termination of pregnancy by choice on such individuals. Weiten (2013:20) defines psychology as the science that studies behaviour and the physiological and cognitive processes that underlie it. These definitions imply that psychological effects are the changes on the behaviour as a result of the physiological and the cognitive processes.

For the purpose of this study the psychological effects of CTOP are the behavioural, the physiological and the cognitive changes caused by termination of pregnancy by choice.

1.4.2 Termination of pregnancy (TOP)

For the purpose of this study TOP is a procedure performed to end pregnancy from the thirteenth up to the twentieth week. In South Africa it is legalised through The Choice on Termination of Pregnancy Act 92 of 1996 (Boezaart 2010:24).

1.4.3 Adolescent

According to Hornby (2005:20), an adolescent is a person who is developing from childhood into adulthood. Weiten (2013:433) states that the age boundaries of adolescence are not exact but are thought to be between ages 13 and 22. Weiten (2013:434) further explains that the beginning of adolescence is marked by maturity of sexual functioning.
For the purposes of this study an adolescent will refer to a female aged 18-21 years who has been pregnant and had terminated pregnancy by choice.

1.5 RESEARCH PURPOSE, OBJECTIVES AND QUESTIONS

This section will discuss the research purpose, objectives and research questions.

1.5.1 Research purpose

The purpose of this study is to investigate the psychological effects on adolescents after termination of pregnancy by choice.

1.5.2 Research objectives

The research objectives of the present study are to

- explore and describe the experiences of adolescents after TOP
- explore and describe the factors contributing to the decision for TOP
- identify and describe the psychological effects after TOP

1.5.3 Research questions

The research questions for this study emanate from the study objectives and are:

- What are the experiences of adolescents after TOP?
- What influences decision-making about TOP?
- What are the long term psychological consequences?

1.6 METHODOLOGY

Qualitative exploratory and descriptive research will be used. The research will utilise qualitative interpretive (phenomenological) approach in which the researcher enters another’s world to discover the practical wisdom and develop a deeper understanding found there (Polit & Beck 2008:229).
This study seeks to investigate the psychological effects on adolescents after termination of pregnancy by choice, and will do so by identifying factors influencing psychological morbidity and exploring the adolescents’ experiences after TOP. The researcher will therefore enter into active dialogue with the participants and through immersion in their world she will develop a deeper understanding of their experience and identify the psychological effects of TOP. During data analysis, the researcher will analyse interview transcripts over and over again so as to gain a deeper meaning, interpretation and understanding of the phenomena. The methodology will be discussed in detail in chapter 3.

1.7 STRUCTURE OF THE THESIS

The thesis will be structured according to chapters as outlined in table 1.1.

Table 1.1: Structure of the thesis

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<tr>
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</tr>
<tr>
<td>6</td>
<td>Conclusion, limitations and recommendations</td>
<td>General study conclusions, limitation of the study and recommendations are given in this chapter.</td>
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1.8 CONCLUSION

An overview of the study has been given in chapter 1 and chapter 2 will review relevant literature for the study.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Various articles pertaining to the psychological impact of choice on termination of pregnancy (CTOP) amongst adolescents are reviewed here. Sources on adolescence as a stage of development, identification and exploration of psychological symptoms occurring amongst adolescents after termination of pregnancy (TOP) by choice, post-abortion morbidity as well as the factors underlying reasons for regretting aborting are assessed since these play a role as determinants of the psychological outcome of termination of pregnancy.

Other important considerations here are factors that influence CTOP decision-making among adolescents, the demographic and the socioeconomic background as these factors influence the psychological state of the woman after termination of pregnancy by choice. Before the advent of debates and legislation regarding TOP, the public generally believed that human life started at quickening or at birth and therefore abortion was not seen as termination of life, a practice seen by some institutions and the general public as morally wrong (Ehrlich 2006:9). As early as 1854, the medical profession, through their knowledge regarding foetal development, were already assisting legislators in the preparation of laws regarding abortion. The fact that during that period abortion was seen as murder and therefore a criminal offence (Ehrlich 2006:8), it had an influence on the formulation of restrictive abortion laws.

CTOP in South Africa and in many other countries over the world was introduced as a safe measure to solve the problem of unwanted pregnancies and prevention of maternal deaths caused by backstreet terminations.

Despite this intention, findings of depression following CTOP amongst adolescents have been reported in some studies.
CTOP is rife with conflicting debates amongst lawyers, with some courts believing that it causes mental ill-health. The health personnel is also divided on the issue that CTOP is murder of human life and can therefore cause guilt feelings and subsequent depression on some women.

2.2 CHOICE ON TERMINATION OF PREGNANCY ACT

The South African Choice on Termination of Pregnancy Act 92 of 1996, that was implemented in 1997 and amended in 2008, repealed the Abortion and Sterilisation Act (Act 2 of 1975) in so far as it relates to abortion. The Abortion and Sterilisation Act restricted abortion with a penal sanction, except in certain situations, such as when the prolonged pregnancy put the life of the woman concerned in danger (Boezaart 2010:25). In terms of section 2(1) of the Choice on Termination of Pregnancy Act 92 of 1996 (Boezart 2010:25) the termination of a pregnancy by a qualified health practitioner within the first twelve weeks of gestation is absolutely legal.

The Act obliges the state to promote the provision of non-mandatory and non-directive counselling before and after CTOP (Boezaart 2010:25). This is provided because CTOP can cause physical and psychological complications. According to Gouws, Kruger and Burger (2000:173), complications may include future miscarriages, future premature deliveries and low-birth mass, ectopic pregnancies, placental complications or sterility. Psychological problems may be depression, anger, nightmares, grief, regret, loss of interest in sex or fear of punishment.

In South Africa, the law does not acknowledge that CTOP can lead to depression because there is still controversy on this issue. In the case of Christian Lawyers Association versus Minister of Health (Reproductive Health Alliance as Amicus Curiae) 2005 (1) SA 509 (T), the association opposed the provisions that allow minors to terminate their pregnancies without parental consent. They argued that a minor is incapable of consenting and that these provisions infringe on the child’s right to parental care and the right to be protected from abuse.

The public policy of some states of America requires physicians to inform patients that abortion will increase their risk of depression and suicidal tendencies (Zolese & Blacker 1992:742), that abortion is linked to breast cancer, that the foetus has the ability to feel
pain during the procedure of abortion and about the long-term mental health consequences after abortion (Guttmacher Institute 2014:1).

Guttmacher Institute’s (2014:1) overview on abortion laws in the USA highlights differing legal provisions and restrictions between the states. Forty-two (42) states prohibit abortion, 18 states require a second physician to be involved during the procedure, some states use public funds to pay for medically necessary abortions whilst others prohibit the use of state funds for termination of pregnancies, still some refuse coverage of abortion in private insurance plans. In some states individual health care providers are allowed to refuse to participate in an abortion. Waiting periods vary from 24 hours between a woman receiving counselling and the procedure being performed, to a woman required to make two separate trips to the clinic to obtain the procedure. These restrictions either make it difficult for a woman to obtain TOP, discourage women from continuing with TOP or give the woman time to think about her decision to terminate the pregnancy.

In the researcher’s opinion the law in South Africa, unlike in the United States, is still not explicit on the complications that may arise after CTOP, especially those related to mental health amongst adolescents.

2.3 ADOLESCENCE

Adolescence is the transitional period between childhood and adulthood. According to Weiten (2013:433), its age boundaries are not exact. The period may differ amongst cultures, with notable physical changes, physiological changes, neural development and a search for identity (Weiten 2013:435).

This study is based on adolescents aged 18-21 years and according to Arnett (2006), this period is specifically referred to as the period of emerging adulthood.

During adolescence, the prefrontal cortex of the brain is still not yet fully developed. The prefrontal cortex is characterised as the control centre of the brain. It is crucial to high level cognitive functions such as planning, organising, emotional regulation, sense of responsibility, moral sense and response inhibition (Casey et al 2005 as cited in Weiten 2013:435). This reality may contribute to adolescent’s risk taking behaviour, their
inability to accept responsibility for child rearing and irrational reasoning regarding aborting or not as well as their response to peer pressure. Theorists suggest that immaturity of the prefrontal cortex explains why risky behaviour peaks during adolescence and declines during adulthood. It may also account for adolescents regretting aborting in their later years as they will reason differently about termination of pregnancy in subsequent years when they are adults. This is supported by Dryfuss (1990:25) as cited in Hlalele (2008:9) that an adolescent is still in the process of acquiring the competencies necessary for adult roles, such as problem-solving and decision-making skills.

CTOP decision-making amongst adolescents may be a complex and a sensitive issue with some initially requesting termination and then changing their minds later. As Hlalele (1998:65) as cited in Hlalele (2008) states, adolescent pregnancy is usually unwanted and unplanned. A pregnant adolescent at school may be influenced by factors that do not affect older pregnant women. It leads to an experience of conflicting emotions as the woman struggles with the decision to terminate or not to terminate.

The decision to terminate or not to terminate is made in the context of relativistic thinking, future time perspective, means-end thinking, moral reasoning and other cognitive social domains (Brodzinsky & Schechter 1990:306).

According to Rodman (1991:158) as cited in Hlalele (2008:11), the decision is important because most of the time it is about leaving school or not and it will continue to reverberate later in the woman’s life. The decision is also urgent because her unintended pregnancy develops rapidly whilst she has to come to terms with it and how to resolve the situation. This urgency to make a decision about TOP may cause the adolescent to end up reasoning irrationally, taking into consideration the nature of adolescents’ thinking skills.

2.4 REASONS FOR TERMINATION OF PREGNANCY

According to Lowen (2008:15), TOP by choice is more likely amongst those adolescents who are still attending school and are under pressure from a partner or parents. Other reasons for TOP among adolescents would be for those adolescents, who have other
emotional issues, who have moral or ethical issues that are opposed to teenage pregnancy outside marriage or who lack a support system (Lowen 2008:15).

Hlalele (2008:9-21) adds culture, religion, marital status and education as other reasons for termination. Price (1983:149-150) as cited in Hlalele (2008) contends that parents often respond to adolescent pregnancy with anger and may feel ashamed of their daughter's immoral behaviour. These feelings cause parents to influence the pregnant adolescent’s decision to terminate pregnancy. An adolescent making a decision under such pressure may feel angered after TOP because she failed to protect her “baby” from being aborted.

On the other hand, an adolescent may choose to abort as a way of hiding her sexual activity and pregnancy from her parents. Such a decision may be influenced by religiosity of the parents, fear of rejection by parents or peers.

In South Africa, the law regarding the choice on termination of pregnancy does not make it mandatory that parents should give consent to a minor to terminate pregnancy, unlike in the United States of America, where parents are expected to support minors who want to terminate their pregnancies.

As observed by the researcher, most adolescent mothers' lives are negatively impacted by the birth of a baby. Their educational plans are interrupted, and this will subsequently limit their earning potential in the future, thus risking raising a child in poverty. Teen mothers are less likely to complete their high school education.

Most adolescents choose to abort because they do not want their lives to be changed by the birth of a baby as they may feel that they won't be able to afford a baby (Lowen 2014; Hlalele 2008).

Religion and culture largely dictate belief systems and codes of behaviour in any society and in turn play a role in the development of societal attitudes towards adolescent pregnancy and abortion. According to Hlalele (2008:14-15) such constructs may influence the pregnant adolescent to terminate or not terminate a pregnancy.
Findings of a study conducted by Ortiz and Nuttal (1990:898) as cited in Hlalele (2008:15) to determine the effects of religion on the decision to carry or terminate pregnancy among Puerto Rican teenagers showed a significant correlation between religion and fertility patterns. Girls who attend church are more likely to carry to term than those who do not attend church quite as often. For adolescents belonging to religious groups who openly oppose TOP, religiosity may cause conflicting ideas on an adolescent who wants to terminate her pregnancy.

Such adolescents, according to Hlalele (2002:239), will report more feelings of guilt if they terminated their pregnancies. Other psychological difficulties experienced by adolescents who terminated are lowered self-esteem, stigmatisation, withdrawal, flashbacks and isolation.

From the above discussions, it is noted that adolescents, by the time they undergo TOP, they are already experiencing some form of stress related to religiosity, family morals and culture, the urgency of the decision about TOP, the future of their education as well as the stigma of unplanned pregnancy and abortion. Gouws et al (2000:151) also note that the effect of one stressor is enhanced if it is combined with another stressor. Stress therefore has a multiplicative effect in that more psychological problems will be experienced where a pregnant adolescent has more than one stressor.

Robinson, Stotland Russo, Lang and Occhiogrosso (2008:268) also concluded that the most consistent predictor of mental disorders after termination of pregnancy remains pre-existing disorders, which in turn, are strongly associated with exposure to sexual abuse, intimate violence, childhood adversity, financial problems and poor coping capacity. These factors increase the risk of poor mental health, whether or not a woman has an abortion.

They further state that studies that assert a causal connection between abortion and subsequent mental disorders are marked by methodological problems, including poor sample and comparison, group selection, control of relevant variables, inappropriateness of statistical analyses, errors of interpretation, failure to control for confounding factors and misattribution of causal effects.
Most studies of termination of pregnancy in adolescents, according to Warren, Harvey and Henderson (2010:230), have compared the psychological outcomes in adolescents with those in adult women. Such comparisons do not directly address the question of whether termination of pregnancy has adverse psychological effects for adolescents. Findings of such studies are invalid because reactions of adults and adolescents are not the same.

2.5 PSYCHOLOGICAL IMPACT OF CTOP

According to Hornby (2005:1172) the term psychological implies “connected to the mind” and the term effect means a change that something causes in something else or a result (Hornby 2005:465). Psychological effects of CTOP on adolescents are therefore mental changes caused by CTOP on such individuals. Weiten (2013:20) defines psychology as the science that studies behaviour and the physiological and cognitive processes that underlie it. These definitions imply that psychological effects are the changes on the behaviour as a result of the physiological and the cognitive processes.

For the purpose of this study the psychological effects of CTOP on adolescents are the behavioural changes caused by CTOP, resulting from the physiological and the cognitive processes.

Termination of pregnancy among adolescents is a relatively minor and safe procedure with very limited immediate physical impact. However, psychological effects are less clear and in most cases unknown. There is a contrasting view in literature on whether termination of pregnancy causes psychological harm or not. The topic on psychological impact of abortion has fuelled debates.

Trybulski (2005:683) shows that women do experience depressive symptoms after termination of pregnancy and that their thoughts, emotions and insights about the meaning of these experiences were on-going as life events unfolded. There is a need to specifically study the psychological effects of choice on termination of pregnancy amongst adolescents as most of the studies carried out in this area pertain generally to women of all age groups.
In a study by Charles, Polis, Sridhara and Blum (2008) regarding the search for articles focused on the potential association between abortion and long-term mental health outcomes published between 1989 and 2008, 21 studies were systematically reviewed. The highest quality studies regarding methodology had findings that were neutral, suggesting few, if any, differences between women who had abortion and their respective comparative groups in terms of mental health sequelae. Conversely, studies with the most flawed methodology found negative mental health sequelae of abortion.

An expert panel appointed by American Psychologist Association (APA) to review literature on the psychological effects of abortion (Adler, David, Major, Roth, Russo & Wyatt 1992b:1195), concluded that abortion is not likely to be followed by severe psychological responses. They also stated that psychological aspects can best be understood within a framework of normal stress and coping rather than a model of psychopathology.

Some authors state that the psychological reaction of women and teenagers to abortion is influenced by their reasons for aborting (Ehrlich 2006:256), their personal, economic, social and cultural context (Rousset et al 2011) as well as age (APA Task Force Report 2009:3). Existence of a stressful situation before or during pregnancy may lead to a sense of relief or to continued stress.

Robinson et al (2008:269) note that a decade ago, reviews of scientific literature on the psychiatric sequelae of abortion concluded that adverse symptoms occur in a minority of women, and when they do occur, their strongest predictor is mental health before the abortion.

Jama (1992) as cited in Robinson et al (2008:269) published a commentary that stated that there is no scientific evidence that supported the existence of a psychiatric diagnosis related to induced abortion. In a study by Robinson et al (2008:271), the authors state that the most consistent predictor of mental disorders after abortion remains pre-existing disorders due to pre-existing stressors and problems. Studies that do not take into account pre-existing or co-occurring stressful circumstances in the lives of adolescents having abortion may attribute emotional distress to the abortion when it is actually due to those other circumstances.
Since then, literature on the subject has grown, with studies concluding that TOP either does or does not cause mental health problems. Terms like post abortion depression and psychosis as well as abortion trauma syndrome have since been postulated.

Such claims have been used as rationale for changes in public policies for example, in the United States. They have also affected organisations such as Doctors for Life and the Christian Lawyers Association in South Africa.

Despite such claims, the evidence on the linkages between TOP by choice and mental ill health proves to be relatively weak, although some studies find evidence of this linkage (Reardon & Cougle 2002). In a study conducted by Oregon University and University of California amongst teenagers who aborted by choice, it was concluded that young women were no more likely to become depressed or have low self-esteem within the first year or five years after termination by choice as compared to their peers who were pregnant, but did not have an abortion (Warren, Harvey & Henderson 2010:230).

Warren et al (2010) carried out a nationally representative study amongst adolescents to identify any association between abortion, low self-esteem and depression. The survey was carried out among 69 adolescents and they were followed up within the year of pregnancy and 5 years after termination of pregnancy. In this study, controlling for mental health prior to the pregnancy and assessing outcomes at two time points were undertaken for validity of outcomes. Prior depression was measured in the year before their pregnancies and that was a more precise observation. Socioeconomic and demographic variables were considered for control in that study because economic hardships may predict abortion and risk of depression or low self-esteem.

The study revealed that abortion was not associated with depression or low self-esteem. The adolescents who had an abortion were no more likely to become depressed or have low self-esteem than were their peers whose pregnancies did not end in termination. Sometime, social disadvantage, not TOP, is itself a cause of poor mental health (Warren et al 2010:234).

Despite these findings, there are claims by some authors (Fergusson, Horwood & Ridder 2006; Cougle, Readon & Coleman 2001) that termination of pregnancy by young
women has harmful consequences for mental health. Legislation in the USA’s 34 states currently require that women receive counselling before TOP by choice, seven of these states specifically require that women be warned of possible negative psychological consequences resulting from the procedure. According to Warren et al (2010), such advice may jeopardise women’s health by adding unnecessary anxiety and undermining women’s right to informed consent. The content of counselling may therefore impact on the mental state of the adolescent before and after termination of pregnancy.

In a study by Broen, Moum, Bodtker and Ekeberg (2005:3) comparing women who experienced miscarriage and those who terminated by choice in Norway, women were interviewed and they completed questionnaires 10 days, 6 months, 2 years and 5 years after pregnancy termination. There was a difference in psychological responses between women who terminated by choice and women who miscarried. Women who aborted by choice scored higher for anxiety and depression throughout the 5 year period of observation and women who miscarried improved for depression and anxiety after 10 days.

Franz and Reardon (1992), as cited in Andrews and Boyle (2003:417), compared responses of adult and adolescent women to abortion. Mailed questionnaires contained questions about negative feelings about abortion. Adolescents in the study reported greater psychological distress following abortion as compared with adults. They also reported that they were pressured to have an abortion. This could cause them to harbour anger against those who pressured them to abort. It may be that negative emotional reactions occur in women who do not make the decision about abortion themselves.

Ely et al (2010) researched the relationship between depression and other psychosocial problems in a sample of adolescents who terminated pregnancy. Of the 120 respondents, 40% reported elevated signs of depression (Ely et al 2010:276). Those who reported depression reported additional psychosocial problems more than those who reported insignificant depression (Ely et al 2010:277). In this study it is not clear as to whether the psychological problems existed before TOP or not and this threatens the validity of the findings.
A nationwide survey in America was undertaken to compare adolescents who terminated unintended pregnancy with those who carried an unintended pregnancy to term (Coleman 2006:903). The finding was that abortion was positively associated with sleeping problems and reporting for psychological counselling. In that study researchers could not determine whether TOP preceded or followed the outcomes, or whether an unobserved covariate was responsible for the association.

In a study by Yilmaz, Kanat-Pektas, Kilic and Gulerman (2010:542), it was found that women with a high risk of post-abortion depression were significantly younger than those with low risk. This finding may indicate the tendency of adolescents towards post-CTOP depression which may be due to a lack of similar experience. The data of this study also indicates that women with past depressive disorders were at significantly greater risk for post-abortion depression.

Fergusson et al (2006:16-24) did a study on the extent to which abortion by choice had harmful consequences for mental health over the interval from age 15-25 years. This was a 25-year long longitudinal study of a birth cohort of New Zealand children. Information was obtained on history of pregnancy/abortion for female participants over the interval from 15-25 years; measures of mental disorders and suicidal behaviour over the intervals 15-18, 18-21 and 21-25 years and childhood as well as family and related confounding factors. Control for childhood, family and related confounding factors were done. Forty-one percent of women had become pregnant on at least one occasion prior age 25, with 14.6% having an abortion. Young women who terminated pregnancy by choice had elevated rates of subsequent mental health problems which included depression, anxiety, suicidal behaviours and substance use disorders. This association persisted after adjustment for confounding factors.

Table 2.1 shows risk ratios of mental disorder by pregnancy/abortion status after covariate adjustment.
Table 2.1  Risk (95% CI) of disorder by pregnancy-abortion status after covariate adjustment

| Measure                      | Not pregnant | Pregnant No Abortion | Pregnant Abortion | p       | SSSSSSSS
|-----------------------------|--------------|----------------------|-------------------|---------|----------------
| Major depression            | .48<sup>a</sup> | .35<sup>a</sup> | 1<sup>b</sup>    | .006    | 1-4, 6-9
| Anxiety disorders           | .52<sup>a</sup> | .44<sup>a</sup> | 1<sup>b</sup>    | .082    | 2, 4, 8
| Suicidal ideation           | .42<sup>a</sup> | .24<sup>a</sup> | 1<sup>b</sup>    | .004    | 2, 3, 5, 6, 9-11
| Illicit drug dependence     | .20<sup>a</sup> | .15<sup>a</sup> | 1<sup>b</sup>    | .014    | 2, 10
| Number of mental health problems | .66<sup>a</sup> | .58<sup>a</sup> | 1<sup>b</sup>    | <.001   | 2-5, 6, 8, 9

<sup>1</sup>The results of planned comparisons of the adjusted rate of each outcome across the three groups are indicated by the superscripts (***). Different superscripts indicate that the groups were significantly (p<0.05) different in their adjusted rates of disorder. Similar superscripts indicate that groups were not significantly different in their adjusted rates of disorder.

<sup>2</sup>Significant covariates: 1=maternal education; 2=childhood sexual abuse; 3=childhood physical abuse; 4=child neurotism (14 years); 5=child self-esteem; 6=grade point average (11-13); 7=child smoking (15 years); 8=prior history of depression/anxiety (15 years); 9=prior history of suicidal ideation (15 years); 10=living with parents; 11=living with partner (Fergusson et al 2006:20).

For four of the five outcomes (depression, suicidal ideation, illicit drug dependence, total mental health problems) the association with pregnancy-abortion history remained statistically significant (p<0.05) after control for confounders. For the remaining outcome, anxiety disorder, the adjusted association was marginally significant (p=0.08).
Those who were not pregnant and those who were pregnant without abortion had adjusted rates of disorder that were not significantly different ($p > .05$). However, in all cases, the abortion group had significantly ($p < .05$) higher rates of disorder than the pregnant no abortion group, and with the exception of anxiety disorder, significantly ($p < .05$) higher rates than the not pregnant group.

The strengths of that study was the use of a longitudinal design where pregnancy and mental health were assessed throughout adolescence into young adulthood, the availability of a range of concurrent and prospectively assessed covariate factors as well as adjusted contrasts between those having abortion and equivalent groups of those becoming pregnant and those not pregnant.

A possible threat to validity in that study though is that the apparent associations between abortion and mental health in it may not reflect the traumatic effects of abortion *per se* but rather other factors which are associated with the process of seeking and obtaining an abortion for example picketing done by prolife groups at TOP clinics.

### 2.6 FEELINGS AFTER CTOP

Most women feel a sense of relief immediately after abortion and sometimes a deep feeling of sadness may set in as well (Johnson 2014:1). It still needs to be confirmed as to what exactly is the post abortion woman relieved from. Is she relieved from the procedure of TOP or from termination of continuance of the life of a foetus? If the woman was pressured into having an abortion she is more likely to feel negative emotions.

A number of authors proposed that long-term mental disorders following abortion may be due to feelings of unresolved loss (Ney, Fung, Wickett & Beaman-Dodd 1994) as cited in Fergusson et al 2006:18). Social stigmas about abortion can make it difficult for some women to share their experiences and make them feel isolated or judged. Suppressed grief leads to other psychological problems.
2.7 CONCLUSION

Studies on issues surrounding psychological impact of CTOP were reviewed in this literature search. Although there is still controversy regarding the psychological impact of CTOP, there is evidence that some women do experience negative emotions associated with TOP and others express a sense relief. This topic is made difficult by the fact that some women suppress the emotional pain or hide that they ever had abortion.
CHAPTER 3

DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to provide the overview of the research design and methodology that the researcher intends to use in order to obtain information about the psychological experiences of adolescents, 18 to 21 years old, regarding termination of pregnancy by choice. The research design, research methodology, data collection, measures to ensure trustworthiness, data analysis and conclusion will be discussed in some detail. Polit and Beck (2012:733) define methodology as the steps, procedures and strategies for gathering and analysing data in a study.

3.2 METHODOLOGY

This section will cover the research strategy, design, context, population, sampling, data gathering and analysis.

3.2.1 Research strategy

According to Botma, Greeff, Mulaudzi and Wright (2010:189), research strategy entails the skills, the assumptions, enactments and material practices researchers use when they move from a paradigm and a research design to the collection of empirical materials. A strategy connects the researcher to specific methods for collecting and analysing empirical materials. The qualitative research strategy used in this research is phenomenology. In phenomenological strategy the researcher describes the lived experiences of individuals about a phenomenon as described by participants (Creswell 2009:14). Phenomenology accepts that each person is unique and has their own life experiences (Polit & Beck 2008:227). The researcher will describe the lived experiences of adolescents about TOP as described by participants.
3.2.2 Research design

A research design is a plan, structure and strategy of investigation so conceived as to obtain answers to research questions or problems (Burns & Grove 2011:49). Its aim is to obtain accurate, objective and valid information in order to answer research questions validly, objectively, accurately and economically (Kumar 2012:94). For the purpose and objectives of the present study, a qualitative design will be appropriate in order to explore the psychological experiences of adolescents, 18 to 21 years old, regarding termination of pregnancy by choice and to recommend the best practices in counselling and caring for these adolescents before and after termination pregnancy by choice. In addition, a qualitative design will be appropriate because the phenomenon under study is deeply rooted in the participants personal knowledge or understanding of themselves and is of a delicate and a sensitive nature, thus making the participants vulnerable.

3.2.3 Definition of qualitative design

Qualitative research is the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials, using a flexible research design (Polit & Beck 2008:763). According to Kumar (2012:20), qualitative research is used to explore experiences, meanings, perceptions and feelings. Botma et al (2010:211) observe that qualitative research provides in-depth exploration and description of a phenomenon that differs from the broad explanation that quantitative research provides. Qualitative research is anti-positivistic, idiographic, holistic in nature and uses non-statistical methods and small samples, often purposively selected. (De Vos, Strydom, Fouché & Delport 2011:65). According to Grove, Burns and Gray (2013:23), qualitative research is a systematic, interactive, subjective, holistic approach used to describe life experiences and give them meaning. The qualitative researcher is concerned with describing and understanding how the participants perceived their situation after TOP. Qualitative research is often the only research approach used when the aim is to get an in-depth sense of what people think of a particular event (Joubert & Ehrlich 2007:135). In this study, words will be used to explore and describe the experiences of adolescents after choice of termination of pregnancy. The researcher is motivated to use the findings of this study to improve the information given to women during pre-counselling prior TOP. The problem is that there is no follow-up done on
clients after termination of pregnancy at most TOP clinics. Health personnel need to observe the impact of TOP on adolescents and to intervene where necessary.

3.2.4 Nature of qualitative research

The researcher will use a qualitative research that is explorative, descriptive, interpretive and contextual in nature in order to learn of the experiences of adolescents who chose to terminate pregnancy.

3.2.4.1 Descriptive research

According to Polit and Beck (2008:226), descriptive research focuses on the why and the how of an experience, thus presenting specific details of a situation. The experiences of adolescents after CTOP as well as their deeper meanings will be intensively examined after interviewing participants thus leading to thicker description.

3.2.4.2 Explorative research

Explorative research, according to Kumar (2012:11), is conducted to explore an area where little is known about a situation, a phenomena or an individual in order to get acquainted with a situation. The researcher aims to become acquainted with basic facts and create a general picture of conditions.

In this study individual adolescents will be interviewed in order to gain insight into their emotional and psychological experiences about CTOP.

In order to obtain information, a variety of data collection methods, including a grand tour questionnaire, tape recorded interviews, non-structured interviews, field notes and observations will be used.

3.2.4.3 Interpretive research

According to De Vos et al (2011:08), interpretive approach is also called the phenomenological approach, which is an approach that aims to understand people. Phenomenological approach maintains that all human beings are engaged in the
process of making sense of their worlds and continuously interpret, create, give meaning, define, justify and rationalise daily actions. In this study, through an interview, the researcher will engage participants to interpret, create, give meaning, define, justify and rationalise their psychological experiences after CTOP. According to Holzemer (2010:129), interpretative research and qualitative research are used interchangeably and they seek answers to questions about how experiences are created and given meaning. In this instance, in order to get answers to the research problem, the qualitative inquiry methods will include: a grand tour question, written reflective diaries if any, tape recorded one-on-one in-depth interviews, observation and field notes. The researcher will also gain a sense of subtle, non-verbal communication from participants.

3.2.4.4 Context and qualitative research

Qualitative studies, as according to Botma et al (2010:195), are always contextual as the data are only valid in a specific context. The data of this study will be valid in the specific context of Kalafong Hospital TOP clinic and will therefore not be meant for generalisation of the findings (Botma et al 2010:195).

The researcher will be focused on the experiences of adolescents after CTOP, giving a rich, thorough, vivid and contextualised description of the experiences of adolescents after termination of pregnancy.

3.2.4.5 Type of qualitative research

In this study exploratory, descriptive and contextual qualitative design will be used.

The purpose of exploratory research will be to develop an understanding of how adolescents experience TOP. This phenomenon will be described and explained. Descriptive research entails precise measurement and reporting of the characteristics of the phenomenon (Botma et al 2010:51). Questions asked will seek to understand, to describe and to explain the meaning that adolescents associate with their experience of termination of pregnancy by choice. An applied research will be undertaken in order to generate knowledge regarding the psychological effects of CTOP on adolescents. The findings of this study will directly improve clinical practice regarding the care of adolescents before and after TOP.
3.2.5 The philosophical perspective

The philosophical perspective of this qualitative study will be guided by interpretivism and phenomenology. A philosophy is a set of ideas or beliefs relating to a particular field or activity (Botma et al 2010:40). According to Botma et al (2010:43), interpretivism relates to how people interpret their own world through thinking about a phenomenon. In this study, the researcher will gather knowledge from adolescents on how they understand meanings, values and ideas that they attach to their termination of pregnancy by choice.

3.2.6 The setting

The study setting where interviews will be conducted will be an office at Kalafong hospital, an academic hospital which is in Tshwane municipality, in the Gauteng Province of South Africa. The TOP clinic is run by two registered nurses. Women come to undergo TOP and thereafter no follow up appointments are secured with the clients. Kalafong hospital serves the townships of Atteridgeville, Laudium, Danville, Kwaggasrand, Lotus Gardens and a number of informal settlements. Clients seen at the hospital are mainly Blacks, Indians, and Whites. Potential participants will be traced from the records of Kalafong hospital TOP clinic.

3.2.7 Population

A population is the entire group of persons that is of interest to the researcher and that meets the criteria which the researcher is interested in studying (Brink 2006:113). Representative numbers will then be sampled from the said entire group as the research sample.

3.2.7.1 Inclusion criteria

The target population for this study should meet the following criteria:

Adolescents aged 18 to 21 years who underwent TOP by choice at Kalafong hospital TOP clinic. They should all be able to consent for themselves.
3.2.7.2 **Exclusion criteria**

For this study, the following will be excluded:

- adolescents who have a medical diagnosis of being mentally disabled
- adolescents who are unwilling to participate in the study
- Adolescents below the age of 18 years
- adolescents who were victims of rape

3.2.8 **Sampling method**

A sample, according to Arkava and Lane (1983:27) as cited by De Vos et al (2002:199), comprises the elements of the population considered for actual inclusion in the study. A sample is studied in order to understand the population from which it is drawn. Purposive sampling, which is a non-probability sampling method will be used.

3.2.8.1 **Non-probability sampling method**

In a non-probability sampling method the researcher determines the most typical characteristics of the participants that should be included in the sample. The inclusion criteria, based on the judgement of the researcher, are created. Only criteria-specific participants should be included in the sample (Botma et al 2010:230). In this study only adolescents who are between the ages 18 and 21 years, who are capable of consenting for themselves and who terminated pregnancy by choice at a TOP clinic, will be included in the study. Exclusion criteria will include adolescents who are mentally disabled, adolescents who suffered from serious mental illness prior TOP and adolescents who were victims of rape.
3.2.8.2 **Purposive/judgemental sampling**

In purposive sampling, according to Kumar (2012:207), the researcher judges as to who can provide the best information to achieve the objectives of the study. The researcher will deliberately select adolescents who have terminated pregnancy a year or longer prior to the study. The adolescents chosen were those aged between 18 years and 21 years and were able to consent for themselves. Specific, readily available adolescents who meet the criteria will be selected to participate. The number will be adequate when saturation of information is achieved in the study. Saturation of data occurs when no additional sampling provides any new information (Kumar 2012:206).

3.2.8.3 **Snowball/network sampling method**

Snowball sampling, which is the process of selecting a sample using networks (Kumar 2012:208), was also used. Each participant was requested to identify other adolescents who meet the inclusive criteria and the adolescents selected by them became a part of the sample and were interviewed. The process was continued until saturation point was reached in terms of the information being sought. The problem of snowball sample is that all participants tend to have the same perceptions or attitudes and this may not give a balanced picture of the problem (Botma et al 2010:234). The researcher will ensure that the ages of participants are well represented.

3.2.9 **Data gathering**

Data collection refers to what the researcher aims to find and how the data will be collected (Botma et al 2010:199). For the purposes of this research, in-depth, face-to-face, one-on-one interviews were used. These interviews were tape recorded. Field notes were also taken.

3.2.9.1 **In-depth interview**

Joubert and Erlich (2007:319) state that in-depth interview is used to elicit behaviours of individual participants. Botma et al (2010:207) define in-depth interview as an attempt to understand the world from the participant’s experience and to uncover the participant’s lived world prior to scientific explanations. At the root of in-depth interview is an interest...
in understanding the experience of participants about TOP by choice and the meaning they make of that experience.

Botma et al (2010:206) note that in-depth interview is an attempt to understand the world from the participant’s experiences and to uncover the participant’s lived world prior to scientific explanations. The researcher is not detached but is engaged in the interaction. The root aim is to understand the experiences of other people and the meaning they make of those experiences.

A “grand tour” question that was asked was “Tell me what your feelings are one year after termination of pregnancy.”

To maintain consistency, the researcher used an interview guide which is a set of predetermined, open-ended questions that guide and do not dictate the interview (Botma et al 2010:209).

The questions did not block the researcher from discussing any unforeseen issues that were not planned for during the course of the interview. Participants were allowed to talk and cover the area in their own way. This method advantaged the researcher as detailed information was needed from individuals for this research.

### 3.2.9.2 Field notes

According to Botma et al (2010:217), field notes are a written account of the things the researcher hears, sees, feels, experiences or thinks in the course of the interview. The researcher used them as part of the data or for verification purposes. At the end of each interview the researcher sat down to jot impressions about the experiences, to complete the notes and to record observations.

### 3.2.9.3 Semi-structured interview

Botma et al (2010:208) state that semi-structured interviews are used to gain detailed picture of a participant’s account of a particular topic. This method was relevant for this research as the issue of the effects of TOP is complex, personal and controversial.
Using this method enabled the researcher to be flexible in probing particular interesting avenues that emerged during the interview.

3.2.9.4 Tape recording

To make the experiences described by participants more real and substantial, the interviews were tape recorded (Greeff 2005:293). Tape recording ensured accuracy of information, it allowed the researcher to concentrate on the interview.

Permission was sought from participants to use the tape recorder and the tape recorder was placed inconspicuously in order to avoid distracting the researcher and making the participant uncomfortable.

3.2.10 Data collection process

Data were collected during the months of July to November 2014. Nursing personnel at the Kalafong hospital TOP clinic assisted with the selection of participants from clinic records, following the eligible criteria. The researcher arranged that the clinic nurse manager contacts participants telephonically to make appointments with them to report directly at the TOP clinic of the hospital. The researcher reimbursed the participants for their transport money and this was clarified to the participants by the unit manager when making appointments. To ensure privacy and confidentiality the researcher interviewed participants in her office at a time agreed on by participants.

Before each interview the researcher explained the contents of the consent form to each participant, had the participant sign the consent form, had the participant provide demographic information and thereafter undertake an in-depth interview.

Greeff (2005:287) as cited by Botma et al (2010:207) defines in-depth interview as an attempt to understand the world from the participant’s experience and to uncover the participant’s lived world prior to scientific explanations. The interest during in-depth interview is to understand the experience of other people and the meaning they make of that experience. Botma et al (2010:207) further note that all in-depth interviews are interactional events and deeply and unavoidably implicated in creating meanings that seemingly reside within participants.
Although in-depth interviews are unstructured, the following format as suggested by Greeff (2005:295) as cited by Botma (2010:207) was followed:

- opening with introductory pleasantries
- explaining the purpose of the research
- explaining the approximate time required for the interview
- emphasis of confidentiality of information
- tape recording and taking notes during the interview
- signed voluntary consent is confirmed
- reminded the participant that she is free to withdraw at any time

Should there be need for counselling, participant will be referred to the TOP clinic sister who is a psychiatric trained professional.

The researcher used a list of questions as stated in the interview guide for guidance during the interview. Questions covered participants’ demographic data, which covered age, marital status, level of education, employment status, religion, ethnicity, duration of the pregnancy that was terminated, number of previous abortions, number of children, marital status as well as mental health before termination of pregnancy.

A “grand tour” statement used was “Tell me what your feelings are one year after termination of pregnancy.”

The list of questions did not block the researcher from discussing any unforeseen issues that were not planned for during the course of the interview. Participants were allowed to talk and cover the area in their own way. This method was advantageous as detailed information was needed from individuals for this research. It gave the respondent an opportunity for personal explanation and a detailed response. The interviews varied from participant to participant but the researcher maintained consistency within the types of questions asked, the depth and detail, and the amount of exploration.

Permission to tape record the interviews was requested from participants. Field notes were taken during the interview. The interviews were conducted in English, Sepedi or
Setswana. The choice of language depended on the participant’s choice. The consent form, though was written in English, was thoroughly explained in Sepedi or Setswana, depending on the participant’s language of choice.

### 3.2.11 Pilot testing

Holloway and Wheeler (2010:341) define a pilot study as a process of testing the research question, usually informally with a few participants who possesses the same characteristics as the sample. Pilot testing for this study was conducted with two participants a month before commencement of the actual study. The central statement was found to be adequate as it allowed participants to talk broadly about their experiences. It also became clear that the 45 minutes to an hour were adequate time duration for the interview.

The two participants that were interviewed in the pilot study did not form part of the final participants for the study.

### 3.2.12 Data analysis


The five basic steps that were followed were:

#### 3.2.12.1 Familiarisation and immersion

This process started while gathering data, with the researcher developing ideas and theories about the phenomenon. The researcher read through the transcripts of taped interviews many times in order to know the data thoroughly.

#### 3.2.12.2 Development of themes

Development of themes involved identification of the main and sub-themes whilst reading the text or while listening to taped interviews. The researcher stayed within the language of the participant in identifying themes and subthemes.
3.2.12.3 Coding

As the researcher identified themes, data were coded and linked to identify themes. The researcher cut and pasted to code and linked the codes to themes.

3.2.12.4 Elaboration

The researcher examined various sections of the text and where they were similar, combined them. In this way similarities and finer nuances were found.

3.2.12.5 Interpretation and checking

The researcher interpreted the analysed text and compiled a written account of her interpretation. The researcher brought richness and deeper understanding of the meaning to the description. Tabulation of the frequency with which certain themes are supported by data were used.

Thereafter the researcher wove the themes together into an integrated picture of the phenomenon under study.

3.3 TRUSTWORTHINESS

Trustworthiness is the degree of confidence that qualitative researchers have in their data and it is assessed using the criteria of credibility, transferability, dependability and conformability (Botma et al 2010:232).

The measures undertaken to establish trustworthiness were, as promoted by Lincoln and Guba (1999:35) as cited in De Vos et al (2011:419), credibility/authenticity, dependability, transferability and confirmability.
3.3.1 Credibility/authenticity

Credibility is a criterion for evaluating integrity and quality in qualitative studies (Polit & Beck 2004:751). De Vos et al (2011:419) state that the goal of credibility is to demonstrate that the enquiry was conducted in such a manner as to ensure that the subject has been accurately identified and described. It refers to confidence in the truth of the data and in their interpretation. Lincoln and Guba (1999) as cited by De Vos et al (2011:420) state the following strategies that will help increase the credibility of qualitative research:

3.3.1.1 Prolonged engagement and persistent observation in the field

Polit and Beck (2008:542) state that prolonged engagement is the investment of sufficient time collecting data to have in-depth understanding of the culture, language or views of the people and to ensure data saturation of important categories. It enables the researcher to build rapport with participants, which in turn makes it more likely that participants will give useful, accurate and rich information. It is an important step in establishing rigor and integrity in qualitative research.

Through persistent observation, which refers to the researcher’s focus on the characteristics or aspects of a situation or a conversation that is relevant to the phenomenon being studied, high quality data will be collected. Prolonged engagement provides scope and persistent observation provides depth.

The researcher spent reasonable time with the participants before she could start the interviewing after the participant signed the consent form. This action allowed participant to relax and to build trust with the researcher.

3.3.1.2 Triangulation of different methods

Triangulation of different methods, according to Polit and Beck (2008:543), involves using multiple methods of data collection about the same phenomenon. In this study, the researcher used tape recorded interviews, a grand tour question, observations, prolonged engagement and field notes. The introductory statement was open-ended
and this was the same for all participants “Tell me about your experiences regarding termination of pregnancy”. This statement encouraged participants to open up and express their feelings and experiences. The face-to-face, one-on-one, in-depth interview was tape recorded and a signed consent was also confirmed in the tape recorder. Field notes on any observation of interest noted were recorded. Data was collected until no new information was received.

3.3.1.3 Peer review and debriefing (group discussions)

Peer review involves sessions with peers to review and explore various aspects of the enquiry (Polit & Beck 2008:548). In peer debriefing the researcher presented the research question, summaries of the written and oral data, emerging themes, researcher’s interpretation of the data and taped interviews to peer debriefers and to the supervisor and one expert in qualitative research at the University of South Africa. Peer review and debriefing are used to enhance accuracy of the account and for objective assessment of the study.

3.3.1.4 Member checks

Member checking is a technique for establishing the credibility of qualitative data, in which researchers provide feedback to study participants about emerging interpretations, and obtain participants’ reactions. It is also carried out in order to verify if the results reflect participant’s realities.

Member checking was done throughout the study after data collection, to allow participants opportunities to scrutinise the researcher’s interpretations. The researcher summarised what has been recorded to participants and asked them to verify or refute it by asking this general question to all participants “Is what I just read to you a true reflection of what you have just said?” A follow up interview and discussion with participants was done in face to face discussions.

3.3.1.5 Formalised qualitative methods such as analytic induction

Data about rich descriptions by adolescents regarding their experiences of TOP were collected by the researcher. This information was thereafter analysed and themes
identified. For the purpose of this study, an interpretive approach which, according to De Vos et al (2011:8), is also called a phenomenological approach, guided the researcher. This approach maintains that all human beings are engaged in the process of making sense of their worlds and continuously interpret, create, give meaning, define, justify and rationalise daily actions. It emphasises detailed reading or examination of a text, which could refer to a conversation or written words.

For the purpose of this study the researcher listened to what participants were saying during the interview that was tape recorded, and then transcripts of these conversations were written down. The researcher read them several times to discover meaning embedded within the text by trying to absorb or get inside the viewpoint it represents as a whole, and then develop a deep understanding of how its parts relate to the whole. This means that true meaning is rarely simple or obvious on the surface – it is reached through a detailed study of the text, contemplating its many messages and seeking the connections among its parts (Neuman 2003:76) as cited by De Vos et al (2011:8). It should be noted that the researchers may bring their subjectivity into the process of discovering meaning.

In this study the researcher used one-on-one, face-to-face, in-depth interviews and any non-verbal observation that is important for this study was noted and recorded. These interviews were tape recorded and thereafter transcribed.

3.3.2 Transferability

Transferability refers to the ability to generalise the data, that is, the degree to which the findings from data can be transferred to other settings or groups (Polit, Beck & Hungler 2001:362). It is the ability to generalise from the findings to larger populations (Botma et al 2010:233). The researcher of this study used a nominal sample and very informative descriptions of data in the research report so that readers of the report can evaluate the applicability of the data to other contexts.

3.3.3 Dependability

Polit et al (2001:363) describe dependability of qualitative data as the stability of data over time. That is, findings will be consistent if the inquiry was replicated with the same
participants and in a similar context. The findings of this study were made open for scrutiny by the supervisor of this research. Field notes and transcriptions were also given to the independent coder who did not participate in this study, to analyse and interpret. The independent coder and researcher met and agreed on themes and categories.

3.3.4 Confirmability

According to Botma et al (2010:233), confirmability refers to the degree to which the findings are a function solely of the participants and conditions of the research, and not of other biases, motives or perspectives. It entails neutrality – which is freedom from bias during the research process and results description.

The criteria applied are the confirmability audit, triangulation and reflexivity. It is similar to replicability in that it requires that other researchers or observers be able to obtain similar findings by following a similar research process in a similar context. When credibility, dependability, transferability and confirmability are all applied then the research findings will be valid and the research will be considered to be of high quality and highly trustworthy.

In this study an independent coder was provided with the research data and consensus was reached on the categories and themes. The findings were supported by quotes from participants’ words as evidence of information provided. Annexure D shows the detailed descriptions on the participants’ words.

3.4 ETHICAL CONSIDERATIONS

The following principles of ethical conduct were adhered to by the researcher:

3.4.1 Permission

Ethical clearance was obtained from UNISA’s Department of Health Higher Degrees Committee before the research could commence (Annexure A). Kalafong hospital also gave permission for the researcher to conduct the study by using Kalafong hospital TOP clinic records to recruit participants (Annexure C).
3.4.2 Consent form

Kumar (2012:244) defines informed consent as implying that subjects are made adequately aware of the type of information you want from them, why the information is being sought, what purpose it will be put to, how they are expected to participate in the study and how it will directly or indirectly affect them. The consent was voluntary and without pressure (Annexure D).

The researcher ensured that participants understood the objectives of the study and are competent to give consent. Sufficient information was given to would-be participants to allow for a reasoned decision and consent was voluntary and uncoerced. The purpose and the objectives of the study, the possible risks were also explained and only thereafter was a consent obtained in order to protect the rights of participants.

Competency, according to Schinke and Gilchrist (1993:83) as cited by Kumar (2012:244) is concerned with the legal and mental capacities of participants to give permission. Even if the consent is written in English the researcher explained in Setswana or Sepedi when necessary (Annexure D).

3.4.3 Principle of beneficence

Brink (2006:32) states that to adhere to this principle the researcher needs to secure the wellbeing of the subject, who has the right to protection from discomfort and harm, be it physical, emotional, spiritual, economic, social or legal. Botma et al (2010:22) supports that risk equates to harm or injury and implies that it is something detrimental that will occur in the future. The following risks were taken into consideration:

- Physical harm in this study may be fatigue as the method of data collection for this study is face-to-face, one-on-one, in-depth interview where probing will be done and where the participant will be expected to recall past and sensitive experiences about their TOP. During the interviews, the researcher provided a drink and a light snack to help overcome fatigue.
- Psychological or emotional harm, according to Botma et al (2010:22), may be due to self-disclosure, introspection or answering personal questions which
cause embarrassment. When participants experience intense emotional manifestation of anxiety, fear, anger or sadness the researcher had made appointments for referral to the TOP clinic unit manager for counselling. None of the participants used these services. However, two of the participants at one stage spoke with a broken voice and the researcher stopped the interview until participants were ready to continue.

• Social harm involves the negative effects of the researcher’s interactions or relationships with the participant (Botma et al 2010:22). In this study it may be realised in stigmatisation of these adolescents who terminated pregnancy. The researcher avoided interviewing participants at their homes as this may raise suspicions from family members where the participant has not disclosed TOP. All interviews were carried out at the researcher’s office away from the clinic where they may be noticed. The meetings were held outside working hours.

• Economic harm, according to Botma et al (2010:23), involves the imposition of direct or indirect financial costs to the participants. This could include costs incurred for travelling to the hospital, financial loss because they had to take time off from work to report for interviewing and time spent with the researcher for interview. The researcher reimbursed the participants the money for travelling. A drink and a snack were provided to the participant. Interviews lasted between 45 minutes to one hour. Dignitary harm, according to Botma et al (2010:23), is incurred when individuals are not treated as persons with their own values, preferences or commitments, but rather as mere means, not deserving of respect. Such harm may occur when informed consent is not obtained. In this study, before each interview, the researcher explained the purpose and objectives of this study and the risks and the benefits involved, confidentiality as well as the fact that participants are free to discontinue their participation at any time. Only thereafter a consent was signed.

3.4.4 Right to privacy, confidentiality and anonymity

The interviews were conducted in the researcher’s office, where only the participant and the researcher were present at an appointed date and time. The information provided by respondents was kept under lock and key and pseudonyms were used to maintain anonymity. In this study, even though pseudonyms’ were used the researcher and participants agreed on the second visits for verification of the data.
The following guidelines provided by Botma et al (2010:17) were observed in this study:

- Only personal and identifying information that is essential for this study was captured on the data sheet.
- As it was necessary to trace the individual back to the data, a code was allocated to the data-collection sheet and the name and code were kept on a master list. The master list was kept locked away and was destroyed as soon as the study was completed.
- Informed consents were not stapled to data collection sheets but were locked away with the master list.
- In reporting, pseudonyms are used.
- Access to confidential information was limited to the researcher, supervisor and the qualitative expert.
- All data information was saved in a memory stick and locked away together with the tape recorders of the interviews. On conclusion of the study all tapes and other identifiable data will be kept safe for 3 years as the period specified by the university and will thereafter be destroyed.

3.4.5 Refusal and withdrawal from the study

Participants were informed that they have the right to refuse to participate in the study and that they could withdraw from it at any time during the course of the study. Furthermore, the researcher informed them that they would be treated with respect and not be penalised in any way should they decide to discontinue their participation.

3.5 CONCLUSION

This chapter covered the setting where research was conducted, population, sampling techniques, data collection methods as well as ethical considerations observed during the study.
CHAPTER 4

DATA ANALYSIS, FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

The previous chapter discussed the methodology in detail. The present chapter discusses the findings and literature control. A literature control was conducted to support the findings of the current study (Polit & Beck 2008:558).

4.2 DATA GATHERING AND ANALYSIS

This section discusses the processes of data gathering and data analysis.

4.2.1 Data gathering

In-depth, face-to-face and one-on-one interviews were conducted on approval by the Higher Degrees Committee of the Department of Health Studies at the University of South Africa (Annexure A). Only two participants were recruited from the study clinic and the rest of the participants were recruited by the snow ball method.

Data were collected during July and November 2014. At the end of each interview, the information was verified with the interviewee. All the interviews were conducted in the researcher’s office at a time and date agreed upon by the participants.

Field notes regarding observations about the participants’ reactions during the interview and about the natural setting where the interview was conducted were noted where applicable.
4.2.2 Data analysis

Thematic analysis was used following interpretive analysis of Terre Blanche, Durrheim and Kelly (2006) as cited by Botma et al (2010:226). In analysing data, the researcher followed the following steps:

*Familiarisation and immersion:* The researcher involved herself in the data to get to know them thoroughly (Botma et al 2010:226). The text was read through many times.

*Development of themes:* main themes and subthemes were creatively identified.

*Coding:* this started while the researcher was identifying themes. This was done manually. Coloured marker pens were used to code and link the themes.

*Elaboration:* which involved examining various sections of the text and if similar, combining them.

*Interpretation and checking:* where the researcher interpreted the analysed text and compiled a written account of her interpretation. Here themes were used to provide structure.

4.2.3 Sample description

The participants were selected according to the criteria specified in section 3.2.7.1. A brief description of each participant is given in Annexure E and pseudonyms were used for the purposes of confidentiality and anonymity.

4.3 FINDINGS OF THE STUDY

Findings of the study include biographical data of the sample, mental health before termination, where TOP was done, the duration of pregnancy, reasons for termination of pregnancy, support systems and the themes and subthemes that emerged from the qualitative data.
4.3.1 Biographical data

Biographical data describe characteristics of participants who took part in the study. Data collected include age, ethnicity, marital status, schooling, employment status, number of children and religious background.

Mental health before TOP was also assessed using questions from the Quality of Life questionnaire (Broen et al 2005:4).

Table 4.1: Biographical data of participants

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-19</td>
<td>2</td>
</tr>
<tr>
<td>20-21</td>
<td>4</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Number</td>
</tr>
<tr>
<td>Coloured</td>
<td>1</td>
</tr>
<tr>
<td>Pedi</td>
<td>2</td>
</tr>
<tr>
<td>Tsonga</td>
<td>2</td>
</tr>
<tr>
<td>Zulu</td>
<td>1</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Number</td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
</tr>
<tr>
<td>Cohabitant</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td>Number</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Primary education</td>
<td>0</td>
</tr>
<tr>
<td>Secondary education</td>
<td>2</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>4</td>
</tr>
<tr>
<td>Vocation</td>
<td>Number</td>
</tr>
<tr>
<td>Employed</td>
<td>2</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
</tr>
<tr>
<td>Type of vocation</td>
<td>Number</td>
</tr>
<tr>
<td>Still training</td>
<td>4</td>
</tr>
<tr>
<td>Regular employment</td>
<td>2</td>
</tr>
<tr>
<td>Temporary employment</td>
<td>0</td>
</tr>
<tr>
<td>Religious background</td>
<td>Number</td>
</tr>
<tr>
<td>Christian</td>
<td>6</td>
</tr>
<tr>
<td>Muslim</td>
<td>0</td>
</tr>
<tr>
<td>Hindu</td>
<td>0</td>
</tr>
<tr>
<td>African tradition</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>Number</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1-2</td>
<td>4</td>
</tr>
<tr>
<td>Age</td>
<td>Number</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
</tr>
<tr>
<td>3 or more</td>
<td>1</td>
</tr>
<tr>
<td>Number of previous abortions</td>
<td>Number</td>
</tr>
<tr>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2 or more</td>
<td>0</td>
</tr>
<tr>
<td>Duration of pregnancy that was terminated</td>
<td>Number</td>
</tr>
<tr>
<td>9 weeks</td>
<td>1</td>
</tr>
<tr>
<td>9 ½ weeks</td>
<td>1</td>
</tr>
<tr>
<td>10 weeks</td>
<td>0</td>
</tr>
<tr>
<td>11 weeks</td>
<td>3</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.2: Mental health before termination of pregnancy

<table>
<thead>
<tr>
<th>Mental health before termination of pregnancy</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>I felt fit and strong</td>
<td>2</td>
</tr>
<tr>
<td>My life was worth living</td>
<td>4</td>
</tr>
<tr>
<td>I felt close to another person</td>
<td>5</td>
</tr>
<tr>
<td>I felt satisfied with my life</td>
<td>2</td>
</tr>
</tbody>
</table>

In the present study the most represented age group (4 out of 6) was 20 to 21 years old age group followed by the 18 to 19 year old group represented by 2 participants.

Four out of the six participants are single whilst 1 is married and 1 is cohabitating. In their study, Budlender, Chobokoane and Simelane (2004:5) found that cohabitation is a problem amongst most poor women. In this study the contrast is that most women here are single (4 out of 6) and are not cohabitating. On the other hand, Koster-Oyekan (1998) as cited by Hlalele (2008:21) observed that women desire to get married before giving birth and they therefore resolve unplanned pregnancies through termination. Kaplan and Sadock (1994:55) as cited by Hlalele (2008:28) also assert that almost all girls seeking TOP are unwed. In contrast, a 21 year old married woman was asked to terminate pregnancy by her husband.

Five out of 6 participants are Black and 1 is Coloured. The area of recruitment was a township for Blacks hence Blacks were highly represented in the sample.
Four of the six participants (4 out of 6) were still studying at tertiary level. Two completed secondary education and so all participants who were interviewed were literate. Hlalele (2008:16) states that for single women and teenage girls the birth of an unwanted or unplanned child can lead to loss of educational opportunities, diminished chances of a successful marriage and welfare dependency. Hence most of them resolve this dilemma through TOP.

Four of the participants (4 out of six) are unemployed and 2 out of 6 are employed. The four unemployed participants are still studying at tertiary level. Two of the participants are in regular employment. Those in regular employment have secondary education as the highest school qualification. This confirms what Hlalele (2008:23) noted that adolescents opt for TOP in order to continue with their education.

All the participants (6 out of 6) are Christians. Religiosity affects disclosure of pregnancy and TOP as well as dictating a belief system and codes of behaviour. Girls who attend church more frequently will less likely terminate pregnancy. Hlalele (2008:23) further states that for members belonging to religious groups religiosity may serve as a stressor if they were to abort. Where the parents are religious their daughters would avoid informing them about their TOP.

Four out of six had 1 to 2 children. 1 out of 6 had no child and 1 out of 6 had 3 children. Having a child and being single at the same time disrupts continuation of schooling (Hlalele 2008:16). At the same time adolescents feel that they are too young to have children because they do not know how to care for them. Therefore another pregnancy is something that an unmarried mother cannot cope with. In the Black culture a woman who gets a child outside marriage is regarded as “cheap” or as “second hand” (Hlalele 2008:24). Such a societal attitude would likely pressurise a black woman to consider TOP in order to resolve the problem.

Four out of six had never in the past had abortion and 2 out of 6 had previously 1 abortion each. Thevathasan ([s.a.]) observed that a woman may use a defence mechanism of compensation, where she decides to become pregnant soon after abortion in order to substitute for the aborted sibling. Miller (1978) as cited by Thevathasan ([s.a.]) notes that after TOP, many insecure adolescent girls attempt to
become pregnant again – partly to reassure themselves that their uteruses have not been damaged and partly to replace the murdered infant. According to Thevathasan ([s.a.]), repeated abortions are a sign that the woman who aborts has become systematically de-sensitised. In his experience as a psychiatrist, Thevathasan ([s.a.]) states that he learned that women with a low self-esteem may repeatedly do TOP because they feel that they are not capable of being good mothers.

Three out of six terminated at 11 weeks, 1 at 9 weeks, 1 at 9 ½ and 1 was unsure of how old was her pregnancy when she terminated. In South Africa, the Choice on Termination of Pregnancy Act (CTPA) stipulates that any pregnant woman is entitled to termination within the first 12 weeks (Choice on Termination of Pregnancy Act 92 of 1996). Most adolescents would therefore request TOP around this period. The provision of the law regarding termination in South Africa is liberal and does not require adolescents’ parents to give permission for their daughter’s TOP. Hence most adolescents would not delay reporting for TOP as required by law.

On mental health before termination, one half of the participant sample did not feel fit and strong before TOP. Two out of 6 were fit and 1 out of 6 did not respond. From the researcher’s knowledge pregnancy does cause minor physical upsets like anaemia, tiredness, nausea and vomiting. These are therefore expected though within limits.

Four out of six felt that their lives were worth living, whilst 1 out of 6 felt that their lives were not worth living and 1 out of 6 did not respond. This finding tallies with what Fergusson et al (2006:243) stated that there is a tendency for rates of mental health problems to be highest among those having abortions and lowest among those who have not become pregnant, with those who have become pregnant but did not have an abortion having rates that were intermediate between these extremes.

Five out of six had someone they were close to before TOP and 1 out of 6 did not feel close to another person before TOP. Having someone close is important for disclosure and for one to accept her TOP. A study by Coleman (2006:903) affirms that high-risk depression scores were low among those groups who were most likely to report an abortion. Groups who admit an abortion are less likely to experience depression than those who conceal TOP. Major and Gramzow (1999) as cited by Cougle, Reardon and Coleman (2003:137) also state that women who conceal their TOP are more likely to
suppress thoughts of TOP and feel greater psychological distress. Hence 4 out of 6 felt dissatisfied with their lives before TOP whilst 2 out of 6 were satisfied with their lives before TOP.

4.3.2 Themes and categories generated from the study

Two themes and eighteen categories emerged from the qualitative data. These themes and categories will be discussed here and participants’ narratives will be presented to support the findings. The themes and categories generated from the data are displayed in table 4.3.

Table 4.3: Themes and categories generated from the study

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for TOP</td>
<td>• Another child</td>
</tr>
<tr>
<td></td>
<td>• Fear</td>
</tr>
<tr>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Low self-esteem</td>
</tr>
<tr>
<td></td>
<td>• Parents</td>
</tr>
<tr>
<td>Mental trauma</td>
<td>• Guilt</td>
</tr>
<tr>
<td></td>
<td>• Numbness</td>
</tr>
<tr>
<td></td>
<td>• Sadness</td>
</tr>
<tr>
<td></td>
<td>• Confusion</td>
</tr>
<tr>
<td></td>
<td>• Depression and anxiety</td>
</tr>
<tr>
<td></td>
<td>• Shame</td>
</tr>
<tr>
<td></td>
<td>• Anger</td>
</tr>
<tr>
<td></td>
<td>• Sleep disturbances</td>
</tr>
<tr>
<td></td>
<td>• Nightmares</td>
</tr>
<tr>
<td></td>
<td>• Flashbacks</td>
</tr>
<tr>
<td></td>
<td>• Avoidance</td>
</tr>
<tr>
<td></td>
<td>• Anniversaries</td>
</tr>
<tr>
<td></td>
<td>• Survivor guilt</td>
</tr>
</tbody>
</table>

4.3.2.1 Theme 1: Reasons for TOP

The theme of reasons for TOP emerged with four categories: another child, education, low self-esteem and parents.
Category 1: Another child

The majority of the sample (5 out of 6) already had a child and of this group one had three children and the other had two children. Of those with children, three were studying at a tertiary institution and two were working and had secondary education as their highest standard. Four of the five with children are single. All the five with children stated that they did not have finances to bring up another child. Four of the sample were still studying and did not want to interrupt their studies with another child. All stated that another child would be too much.

Table 4.4: Another child

<table>
<thead>
<tr>
<th>Another child</th>
<th>Participants’ narratives</th>
</tr>
</thead>
</table>
| Not coping      | "I already had two kids." (Busi, 21)  
|                 | "I already have three kids." (Bontle, 21) |
| Not married     | "Not ready. I already got a baby in matric and I am not married." (Moso, 21) |

Category 2: Education

Of those with children, three were studying at tertiary institutions and two were working and had secondary education as their highest standard. Four of the five with children are single. Four of the sample were still studying and did not want to interrupt their studies with another child.

Table 4.5: Education

<table>
<thead>
<tr>
<th>Education</th>
<th>Participants’ narratives</th>
</tr>
</thead>
</table>
| Interruption | "I need to continue with studies." (Tumi, 18)  
|             | "Somebody wants to take me to school next year ... I don’t want to disappoint him." (Boitu, 19) |
| Finances    | "I already got a baby in matric. Therefore I can’t cope with 2 kids ... my boyfriend already has a kid with another girl. Financially my parents won’t cope with my second child." (Moso, 21)  
|             | "If I deliver a baby they won’t pay (studies) for me anymore “ (Tumi, 18) |
|             | “… had already 2 kids. Was unemployed. First child autistic … feared that my third child may come with disability.” (Busi, 21) |
According to Andrews and Boyle (2003:414), in their study regarding African-American adolescents’ experiences with unplanned pregnancy and elective abortion, they concluded that the findings suggested that African-American families value education and financial independence and that such values influence adolescent girls’ decisions about unplanned pregnancy and elective abortion. All five participants did not want pregnancy to interrupt their studies. The authors further observed that adolescents’ anticipation of a good education, productive employment and opportunities for success influence decisions of African-American adolescents about unplanned pregnancy and elective abortion.

Hlalele (2008:27) also adds that putative fathers of such adolescents’ pregnancies can be young men of high school age (or tertiary institution). They may urge the girl to procure termination of pregnancy because as fathers they will not afford to support the child. Such fathers are usually still dependent on their parents for finances and will not be able to support a child.

**Category 3: Low self-esteem**

One participant stated that she was pressurised by her partner to terminate. She wanted to keep the baby but she eventually gave in. Two participants were under indirect pressure of parents because their parents would not cope with another child—so their pregnancies were not disclosed to parents and termination was an obvious route to “hide” the pregnancy. One other participant stated that she terminated because she feared her very strict father. Her father sent her to study and not to fall pregnant.
Table 4.6: Low self-esteem

<table>
<thead>
<tr>
<th>Low self-esteem</th>
<th>Participants' narratives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure from others</td>
<td>“I told him (boyfriend) I don’t want to abort. I wanted the kid. He was forcing me to go even when I told him I don’t want to abort. He was going to go with me so that I don’t change my mind.” (Lerato, 20)</td>
</tr>
<tr>
<td></td>
<td>“… most of my friends have done it and they advised me to do it.” (Busi, 21)</td>
</tr>
<tr>
<td></td>
<td>“I had to do it. Somebody wants to send me to school next year. I don’t want to disappoint him.” (Boitu, 19)</td>
</tr>
<tr>
<td>Shame</td>
<td>“I did not tell my family (parents) about abortion. Parents won’t be happy because they have told us not to be pregnant. It’s a shame to do what parents said we may not do.” (Boitu, 19)</td>
</tr>
<tr>
<td></td>
<td>“I feel ashamed. I don’t want others to know.” (Bontle, 21)</td>
</tr>
</tbody>
</table>

Category 4: Parent

One participant feared her father because the father is very strict. Both her parents did not believe in TOP because of their religious disposition. One participant felt that another child would be too much for her parents to maintain. Her father is very religious and she feared disappointing him. One participant stated that she is ashamed of falling pregnant as her parents sent her to college to study and not to fall pregnant.

Table 4.7: Parent

<table>
<thead>
<tr>
<th>Parents</th>
<th>Participants' narratives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t believe in TOP</td>
<td>“My parents did not know about it (pregnancy) and about my intention to terminate. I did not tell them because it is against their belief.” (Moso, 21)</td>
</tr>
<tr>
<td></td>
<td>“My dad would not understand, he is very strict. Both my parents do not believe in it.” (Lerato, 20)</td>
</tr>
<tr>
<td>Fear</td>
<td>“I avoided communicating with my granny. I was afraid to even go outside, to sit with my granny. I slept a lot during the day. I feared she would find out I terminated.” (Busi, 21)</td>
</tr>
<tr>
<td>Disappointment</td>
<td>“Parents won’t be happy because they have told us not to be pregnant.” (Tumi, 18)</td>
</tr>
<tr>
<td></td>
<td>“… parents won’t be happy …” (Boitu, 19)</td>
</tr>
<tr>
<td>Religiosity</td>
<td>My dad is very religious. Mom is not so religious but she is against abortion. I never disclosed.” (Moso, 21)</td>
</tr>
</tbody>
</table>
4.3.2.2 Theme 2: Mental health problems

Several researchers (Fergusson et al 2006; Rausset, Brulfert, Sejourne, Goutaudier & Chabrol 2011; Thevathasan ([s.a.]) have concluded that women experience Posttraumatic Stress Disorder (PTSD) after TOP. Posttraumatic Stress Disorder, according to Weiten (2013:582), involves enduring psychological disturbance attributed to the experience of a major traumatic event. A number of researchers (Rausset et al 2011; McClure-Tone & Pine 2009; Thevathasan ([s.a.]) and Weiten 2013) regard abortion as a traumatic event. Common symptoms, according to Weiten (2013:582) tally with the findings of this study. These include re-experiencing the traumatic event (flashbacks), emotional numbness, anxiety, anger, guilt, low self-esteem, depression, great sense of relief, painful memories (sadness), shame, and sleep disturbances. In the long run there can be addiction to alcohol or drugs as well as suicidal attempts. Not all women experience all of the symptoms.

Category 1: Guilt

All participant (6 out of 6) stated that they felt guilty of murdering/killing their babies.

“…abortion is wrong…it is sin because you kill a person.” (Tumi, 18)

“I am like a murderer.” (Boitu, 19)

“When things didn’t go well for me … I thought it’s because I killed my child.” (Lerato, 20)

“I feel you abort a person who wanted to live.” (Bontle, 21)

Guilt could stem from the belief that TOP is murder or sin as some participants stated. All participants (6 out of 6) stated that they belonged to the Christian religion. Hlalele (2008) contends that religion and culture remain the social attributes that largely underpin patterns of living and may therefore dictate a belief system and codes of behaviour. Religious constructs play a role in the development of societal attitudes and therefore these constructs may influence the way that adolescents react after TOP. Russo and Dabul (1997:24), as cited by Hlalele (2008:15), conclude that, for members
belonging to religious groups that openly oppose TOP, religiosity may actually serve as a stressor if they were to abort. Hlalele (2002:239) and Hlalele (2006:133) found that adolescents who made use of TOP and who were aware that the religion they subscribe to opposes TOP reported more feelings of guilt after terminating pregnancy. Thevathasan ([s.a.]:2) also notes that women express feelings of guilt after terminating pregnancy.

**Category 2: Numbness**

Three out of six participants experienced numbness immediately after TOP. Numbness is a situation where the woman is unable to express her emotions. Participants who expressed feelings of numbness stated that they did not feel anything or that their situation did not appear serious to them. According to Thevathasan ([s.a.]:2), this inability to express emotions may explain why some studies of post-TOP report little evidence of depression or anxiety.

Two of the quotes that alluded to numbness are:

“"I was unable to express my emotions." (Busi, 21)

“I was not feeling anything." (Moso, 21)

**Category 3: Sadness**

Five out of six participants experienced sadness after TOP. The participants reported that they were saddened by seeing the “baby” after the procedure of termination of pregnancy, the structure of the formed foetus, how the foetus was disposed of and also that they did not give the baby a chance to live. The guilt of destroying a life was accompanied by sadness and crying. Even a year after aborting, one participant stated that she felt sad whenever she sees other mothers struggling with their life children. She felt that she should have given her child a chance to live.
“Watching others struggling with their kids, I feel bad … I should have persevered.” (Busi, 21)

“Ga ke ntsę mo, pelo ya ka e bothoko.” (As I am seated here, I am so sad) (Boitu, 19).

“I go to my diary when I am not feeling good, therefore I always cry.” (Lerato, 20)

**Category 4: Confusion**

All participants (6 out of 6) had conflicting emotions about TOP, verbalising some relief and also regret about TOP.

“I feel proud although it’s a shame to do it.” (Boitu, 19)

“I am happy that is over but I also feel sad that I had to terminate this pregnancy.” (Moso, 21)

**Category 5: Depression and anxiety**

Four out of six participants stated that they were either depressed or anxious after TOP. Of the four, two stated that they were anxious even before TOP.

“Yes, I am anxious on and off.” (Moso, 21)

“I cry all the time and I do not want to be around people.” (Lerato, 20)

“The doctor who assisted me made me feel ashamed of myself and now I feel like dirt, I am so depressed.” (Busi, 21)

**Category 6: Shame**

Five out of six participants expressed that they were ashamed of having terminated their pregnancies. This causes them not to disclose to parents the unwanted pregnancy and the intention to terminate the pregnancy. Some participants were ashamed of being seen by others at the TOP clinic, of being involved in pre-marital sex, of others knowing
that they did TOP. An underlying cause for being ashamed of termination of pregnancy is that most believe that TOP is murder or killing. Hlalele (2002:239) and Hlalele (2006:133) found that adolescents who made use of TOP and who were aware that the religion they subscribe to opposes TOP, reported more feelings of shame after terminating pregnancy. Below are some of the voices of the women that demonstrate shame:

“It’s a shame. I don't want others to know.” (Bontle, 21)

“I do not want other people to know about my abortion I am so ashamed.” (Busi, 21)

Most of these expressions were shared by many other participants and explained it as a reason for not confiding in their friends or parents.

Category 7: Anger

Four out of six expressed anger at themselves, to boyfriends or to friends who advised them to terminate.

“I am angry at myself and my boyfriend because he encouraged me...” (Moso, 21)

Category 8: Sleep disturbance

Two out of six mentioned that they experienced sleeplessness during the night.

“Yes. I think a lot during the night, especially after 1am.” (Lerato, 20)

Category 9: Nightmares or dreams

One participant out of six stated that she is haunted by dreams about babies or a child.
“Time and again I have these dreams about children.” (Busi, 21)

“Everytime when I walk around and see children I am reminded of my two that I will never see.” (Lerato, 20)

**Category 10: Flashbacks**

Three out of six participants stated that they re-experience TOP in their minds, especially when they see babies or when people talk about funerals.

“I remember it exactly, especially when people talk about funerals.” (Lerato, 20)

**Category 11: Avoidance**

Five out of six of the sample stated that they avoid thinking about the experience of TOP or do not disclose it, especially to parents.

“I did not tell my family…” (Boitu, 19)

“I avoid thinking about it (TOP).” (Busi, 21)

**Category 12: Anniversary**

Three out of six participants stated that they do something to remember the baby.

“On the date of the TOP I always recall how old the baby would be.” (Moso, 21)

**Category 13: Survivor guilt**

Two out of six participants expressed either feeling guilty of having another child or wanting to replace the aborted child.

“After my first abortion, I fell pregnant again after two months and I wanted this baby. My boyfriend forced me to terminate it.” (Lerato, 20).
Chapter 4 covered findings of the study which elaborated on the biographical data of participants, history of each participant, reasons for TOP, themes and categories which arose from the data collected. The study shows that more participants were unmarried, still attending tertiary institutions or not working. Few had poor mental health before TOP, whilst most participants were experiencing negative mental symptoms after termination of pregnancy. There is need for more intervention in this regard.
CHAPTER 5

DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

The purpose of this study was to investigate the psychological effects among adolescents 18-21 years after choice of termination of pregnancy. In order to meet this aim, the researcher purported to meet the following objectives: explore and describe the experiences of adolescents after TOP; explore and describe the factors contributing to the decision for TOP; identify and describe the psychological effects after TOP.

5.2 STUDY PARTICIPANTS

The participants of this study were only six after identifying about 13 possible participants. The low rates of participation in this type of research have been alluded to in literature (Morris & Orr 2007:7). However, in this study there were no dropouts which is contrary to findings of previous researches that claimed that dropouts are frequent in this type of research (Morris & Orr 2007:7).

Five out of the six participants were Blacks from a low to medium income. The same number of participants was single. This finding is also supported in literature.

5.3 EXPERIENCES OF ADOLESCENTS AFTER TOP

Participants in this study experienced varied emotional including post-traumatic stress disorder, depression, shame, guilt and anger. A number of researchers (Rausset et al 2011; McClure-Tone & Pine 2009; Thevathasan [s.a.]) regard abortion as a traumatic event. Common symptoms include: re-experiencing the traumatic event (flashbacks), emotional numbness, anxiety, anger, guilt, low self-esteem, depression, great sense of relief, painful memories (sadness), shame, sleep disturbances (Rausset et al 2011:508). All these symptoms were also present in the current study. These feelings may lead to alcohol and drug addiction if not attended to (Rausset et al 2011:509).
In their study on depression associated with abortion and childbirth: a long-term analysis of the NLSY cohort, Cougle et al (2002:3) observed that unmarried mothers may have higher depression scores due to the inherent stress of raising a child without support. Five participants that were interviewed already had children before their recent TOP and of the five participants only one was married and supported by her husband. Anxiety may have existed before termination of pregnancy and perhaps made worse by TOP. The procedure of TOP, grieving and the sense of loss, guilt about TOP, lack of support from family may all contribute to anxiety or depression. Nolen-Hoeksema and Hilt (2009:386) in their study on gender differences in depression noted that prevalence of depression is about twice as high in women as it is in men. Essler et al (2003a) as cited by Weiten (2013:589) affirm that the gap does not appear to be attributable to differences in genetic makeup. This means that women are by nature vulnerable to depression or anxiety even outside termination of pregnancy.

Five out of six participants experienced sadness after TOP. They were saddened by seeing the “baby” after the procedure of termination of pregnancy, the structure of the formed foetus, how the foetus was disposed of and also that they did not give the baby a chance to live. The guilt of destroying a life was accompanied by sadness and crying. Even after a year has passed since after aborting, one participant stated that she felt sad whenever she sees other mothers struggling with their life children. She felt that she should have given her child a chance to live.

In their study, Rausset et al (2011:506) have concluded that women experience Posttraumatic Stress Disorder (PTSD) after TOP. Posttraumatic Stress Disorder, according to Weiten (2013:582), involves enduring psychological disturbance attributed to the experience of a major traumatic event.

Sleeplessness was another emotional problem experienced by participants. This finding is also supported in literature that sleep disturbance is a common feature after TOP (Warren et al 2010:231). Sleeplessness may be caused by thinking about the experience too much or worrying about what one has caused or guilt feelings. Nolen-Hoeksema (2001) as cited by Weiten (2013:589) believes that women have a greater tendency than men to ruminate about setbacks and problems. This tendency to dwell on one’s difficulties may cause sleeplessness and subsequent depression.
Five of the six participants reported that they are ashamed of what they did. Shame has been proved to be a strong precursor to low self-esteem and consequently depression (Seloilwe & Thupayagale-Tshweneagae 2009:457). This is further supported by Rousset et al (2011:507) who state that shame can be a risk factor to Post Traumatic Stress Disorder.

Participants also experienced anger. Anger is common where the woman was forced by a partner or a parent to terminate pregnancy against their will. They then become angry at themselves because they failed to protect their babies from being aborted. This self-blame may lead to guilt, to helplessness, to sadness and to anger.

5.4 REASONS FOR TERMINATION OF PREGNANCY

There were many reasons given by the study participants why they terminated their pregnancy. The majority of the participants mentioned education, another child, being coerced by partners, religion, parents’ issues and finances. All these factors have been mentioned in literature (Hlalele 2008:9). In one study, Hlalele (2008:19) mentioned that factors influencing termination of pregnancy are psychosocial in nature and include the economic situation and significant others as well as religion.

Four of the participants were still studying and terminated their pregnancies because they did not want to interrupt their studies. The reason for not wanting to disrupt their education was also associated with the need for financial independence. This finding is supported by Andrews and Boyle (2003:414). Another study by Paluku, Mabuza, Maduna and Ndimande (2010:3), also reported that school going adolescents terminate their pregnancy in order to continue their studies.

The study further revealed that adolescents do terminate pregnancy because they already had another child/ren. Coleman, Maxey, Spence and Nixon (2009:405) in their study on the choice to abort among mothers living under ecologically deprived conditions found that the presence of other children or child may determine whether a mother from underprivileged home terminates pregnancy or not. The reasons for such participants are closely linked to poor economic standing and at times cultural influences (Hlalele 2008:23). A study by Andrews and Boyle (2003:415) noted that
adolescents who had committed abortion are more likely to do it again than those who had not. In this study only one participant had terminated pregnancy twice under duress from the partner.

5.5 CONCLUSION

Chapter 5 discussed some of the key findings of the study and situated them against other similar studies. Chapter 6 will focus on the general conclusion of the study, limitations and recommendations.
CHAPTER 6

CONCLUSIONS, LIMITATIONS and RECOMMENDATIONS

6.1 INTRODUCTION

The aim of this study was to explore the psychological effects of termination of pregnancy by choice on adolescents (18 to 21 year old) and to recommend the best practices in caring for this group before and after termination of their pregnancies. The chapter bears conclusions regarding the psychological effects of termination of pregnancy by choice on adolescents. The conclusions answer the objectives stated in chapter 1.

The possible limitations of the study as well as the recommendations for future research are also presented in this chapter. The recommendations are based on the findings stated in chapter 4.

6.2 CONCLUSIONS OF THE STUDY

Termination of pregnancy remains one of the difficult decisions faced by adolescents and this has been proved in this study. Psychological or mental health problems do occur following termination of pregnancy. Most of the reasons given are similar to what is already known in literature such as guilt, blame, posttraumatic stress disorder and depression. Fear of parents and religion also play an important role in the decision to abort.

It was also established that most of the adolescents who abort were asked by their partners to do so. This shows that the role of male partners in TOP should be considered and more research done in this area.

Pre- and post- counselling for TOP should be emphasised, both in the Choice on Termination of Pregnancy Act and in all clinics that are designated TOP clinics.
Participants in the study reported not having adequate counselling before and after with the counselling all done to explain the procedure.

The findings of the study show that adolescents of ages 18 to 21 experience mental ill health after termination of pregnancy. All participants stated that termination of pregnancy by choice is murder and it is wrong. They expressed feelings of loss, guilt, shame, sadness, sleep disturbances, intrusion, confusion, anxiety, numbness, anger, avoidance as well as survivor guilt. Not every adolescent experienced all these feelings.

6.3 LIMITATIONS OF THE STUDY

There are several limitations of the present study, and the following are some of them:

- Termination of pregnancy is a sensitive and a private topic and therefore it was difficult to get enough adolescents to participate in the study. Most of them had not disclosed to parents and that could have caused them not to want to participate. Only a limited number of adolescents could participate. This in turn makes the sample too small to generalise the findings.
- Follow-ups were also not easy. The researcher had to try several times to fix some of the follow-up appointments. This affected the depth of information needed in some areas.
- The participants were mainly Black adolescents because the area of recruitment was a Black township. This caused over-representation of Black girls in the sample and in turn it threatens generalisability.
- The study was done amongst adolescents, 18 to 21 year olds. The study may be repeated on a broader age group so as to compare the effects of TOP on other age groups.
- Control of confounders was limited. This threatens validity of the findings as mental health might have been negatively affected before TOP.

6.4 RECOMMENDATIONS

The recommendations for this study emanate from the study findings. The recommendations are for the practice and for future research.
6.4.1 Recommendations for practice

For personnel that work with adolescents undergoing TOP, the researcher recommends the following:

• It is important that during pre-counselling to not only focus on the procedure of TOP but to include the emotional and the spiritual impact of TOP as well. The pre-counselling as well as post-counselling must be holistic.
• It is advisable that as part of pre-counselling the counsellor should enquire about any pressure placed on the adolescent to abort. She must be made aware of the negative emotions that may haunt her after TOP as well as the alternatives to TOP. On the other hand, where TOP is done already, the woman must be encouraged to forgive herself and the person blamed for TOP.
• Preferably counselling should be done by someone they do not know, where possible. This makes them not feel judged.
• Professionals who work with adolescent girls need to be made aware of these symptoms so that where a need arises they will be enlightened enough to ask the right questions and refer the adolescent for the appropriate intervention.
• After aborting, a woman is usually not accorded the right to grieve by those around them. The grief is not openly acknowledged, socially validated or publicly observed. Unprocessed grief can lead to depression. It is important that before TOP the adolescent is made aware of the reality of grief as well as the impact of suppressed grief.
• Where possible, the TOP clinic must make follow-up appointments so that holistic counselling is done by a professional who understands what the woman is going through. The present practice in TOP clinics is that the woman is not allowed to report back to the same clinic for any problems related to abortion.
• There is also a need for training of staff who work with adolescents on the psychological effects of termination of pregnancy
• The woman must be encouraged to disclose TOP to someone they trust for support.
• Empowerment on how to work through the emotional pain that may follow should be afforded the adolescent.
- The Choice on Termination of Pregnancy Act 92 of 1996 needs to give mandatory guidance on what should be covered during counselling related to TOP.
- More qualitative research on the topic needs to be undertaken so that the findings may be published for community awareness. Policy makers should be made aware of the findings, so that they improve on the law regarding TOP.

6.4.2 Recommendations for further studies

Since this topic is mostly under-researched because of its sensitivity and inability to draw more participants the researcher recommends the following:

- Duplication of this study in other geographic areas, among other racial groups and age groups should be done to give a clearer picture on the psychological effects of TOP on adolescents.
- Follow-up study of the same group of adolescents may be done to trace the impact of TOP after some years.
- Studies to explore how each variable influences the adolescent’s response to TOP may also be undertaken.
- A comparative study between the different age groups or between the different racial groups on how they respond to TOP.

6.5 CONCLUSION

Chapter 6 covered the general conclusion of the study, the recommendations for practice and future research.
REFERENCES


Christian Lawyers Association versus Minister of Health (Reproductive Health Alliance as Amicus Curiae) 2005(1) SA 509 (T).


