# SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY IN ADOLESCENCE

by

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**DECLARATION**

I declare that **SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY IN ADOLESCENCE** 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 and that this work has not been submitted before for any other degree at any other institution.

22 January 2018

**SIGNATURE** **DATE**

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# SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY IN ADOLESCENCE


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## ABSTRACT


### Background

Literature reveals that reproductive coercion is a major contributor to unwanted pregnancy and a factor that influences the choice to terminate pregnancy in many adolescents. Adolescents represent a population vulnerable to a number of physical and psychological problems.

### Purpose

The overall aim of this thesis was to develop a model of self-forgiveness for women who terminated pregnancy in adolescence.

### Objectives

The study objectives are aligned according to the phases of the study as follows:

*Phase 1: Desk review*
Explore what is already known about the topic and identify gaps.

*Phase 2: Lived experiences of participants about TOP*
Explore the lived experiences of participants who terminated pregnancy in adolescence.

*Phase 3: Development of a model*
Develop a model of self-forgiveness for women who terminated pregnancy in adolescence.

## Theoretical framework

The social-ecological model (Bronfenbrenner 1992), through which individuals are understood to influence and be influenced by people, organisations, institutions, societal norms, rules and beliefs with whom they interact, was followed. The model offered a holistic framework for exploring interrelationships related to TOP

## Methodology

A qualitative approach based on Heidegger (1962) interpretive phenomenological approach was used. The study was conducted at a Health Care Centre in Tshwane Municipality, Gauteng Province, South Africa. The population consisted of women, 20-35 years old, who terminated pregnancy in adolescence.

A purposive and snowball sampling techniques were used to recruit 30 participants who had terminated pregnancy in adolescence. An interview guide was used to solicit information from participants. Audiotaped interviews were held at the time, date and place agreed by participants. Colaizzi's (1978) approach of data analysis was used.

## Results

Five major themes emerged, with 17 sub-themes as transgressing one of nature's strongest instincts: the mother's protection of her young; unplanned pregnancy; intra- and interpersonal relationships; experience of caring by health care professionals and a need for counselling. A model of self-forgiveness for women who did TOP in adolescence, based on the components of self-condemnation and self-blame, cultural and spiritual, as well as reproductive coercion, was developed.

## Conclusion

Participants carried the burden of shame and guilt of having terminated pregnancy in adolescence. The influence of culture and religion were the major contributing factors to women failing to forgive themselves after termination of pregnancy. A model of self-

forgiveness is needed to allow those who terminated pregnancy in adolescence to move on with their life.

**Key words**

Adolescents; adolescence; guilt; intimate partner violence; interpretive phenomenology; narrative; reproductive coercion; shame; self-forgiveness; social ecological model; TOP; unintended pregnancy.

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# *Dedication*

*This study is dedicated to all the women who terminated pregnancy in adolescence and had to endure pain and regret silently throughout their lives. The study is also dedicated to my late parents, Rre Sumakoe and Mmakgabo Kgasoe who taught me to rely on education for a brighter future.*

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| | |
|---|---|
| APA | American Psychological Association |
| BAS | Behavioural Activation system |
| BIS | Behavioural Inhibition System |
| CNS | Central nervous system |
| CTOP | Choice on Termination of Pregnancy |
| DoH | Department of Health |
| EEG | Electroencephalography |
| IPPF | International Planned Parenthood Federation |
| IPV | Intimate partner violence |
| RC | Reproductive coercion |
| SADoH | South African Department of Health |
| SANC | South African Nursing Council |
| SF | Self-forgiveness |
| TOP | Termination of pregnancy |
| UNICEF | United Nations Children's Fund |
| UNDP | United Nations Development Programme |
| UNPFA | United Nations Population Fund |
| WHO | World Health Organization |

# CHAPTER 1

# SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY IN ADOLESCENCE

## 1.1 INTRODUCTION AND BACKGROUND

Self-forgiveness has been framed as a process that helps to facilitate psychological as well as physiological well-being following wrongdoing (Wohl & McLaughlin 2014:422). It alleviates negative feelings related to acknowledged, on-going, wrongful behaviour committed by self. Women who terminated pregnancy may feel that they acted in a way that caused harm to the foetus and to themselves. These negative emotions can be reduced or eliminated through self-forgiveness because it causes release of self-directed negative feelings and replaces them with self-respect, self-compassion and self-acceptance (Cornish & Wade 2015:102).

Pregnancy in adolescence is a public health concern in both developed and developing countries (Dangal 2017:3; Kearney & Levine 2012:141; Mba 2003:36). These studies also reported that adolescent pregnancy has some negative physiological, psychological and social effects on the adolescents. These negative outcomes may be compounded by termination of pregnancy.

Adolescence is a transitional phase from childhood to adulthood (Thupayagale-Tshweneagae 2009:176). It is a stage of life during which individuals reach a period of sexual maturity and is normally defined in the age bracket of 10-19 years (WHO 2011:3). In the previous study by the researcher, she identified the phase of adolescence as a distinct and an important biological and social stage of development (Sebola 2014:56). It is within this premise that adolescent pregnancy becomes a health and social issue for adolescents.

The United States of America (USA) is reported to have the highest numbers of teen pregnancies but very few abortions (Darroch 2001:102). The researcher noted that about 9% of American adolescents become pregnant each year and that 3% of such births end up in abortion. In their recent study, Sedgh, Finer, Bankole, Eliers

and Singh (2015:223), reported that the USA has 57 pregnancies per 1,000 females. In addition, Kearney and Levine (2012:144) reported that a large number of American adolescents, followed by Russia get pregnant and a small percentage of those that get pregnant are likely to abort. The United Kingdom (UK) also has a higher number of adolescent pregnancies while Germany and Switzerland have the lowest number of adolescent pregnancies compared to the USA, UK and Russia (Dangal 2006:262; Fergusson Boden & Horwood 2007:6; Hornig 2012:181).

In Africa, adolescent pregnancy is also a common public health problem and many countries are spending the largest portion of their national budget on measures of prevention with very limited success (Yakubu & Salisu 2018:15). In sub-Saharan Africa, adolescent pregnancy is higher than other parts of Africa. The highest recorded countries with adolescent pregnancy include Tanzania, South Africa and Ethiopia (Yakubu & Salisu 2018:15). Most of the adolescent pregnancies end up in abortion. Teenage pregnancy and abortions are associated with socio-cultural, environmental and economic factors (Phillips & Mbizvo 2016:1).

In South Africa, adolescent pregnancy is a concern to the Government. 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, 80373, was 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 2006:397). Studies (Yakubu & Salisu 2018:15; Sebola 2014:132) found that there are contributing factors to both adolescent pregnancy and termination of pregnancy, and that the overarching factor is reproductive coercion.

Reproductive coercion (RC) is a major contributor to unwanted pregnancies and a factor that influences the choice to terminate pregnancy in many adolescents. Unwanted pregnancy is also the leading cause of maternal morbidity and mortality in the world (Guttmacher Institute 2012a:35). Termination of pregnancy (TOP) has

been linked to a number of physical and psychological problems (Blum & Nelson-Mmari 2004:402).

Some researchers (Rausset, Brulfert, Se'Jourme, Goutaudier & Chabrol 2011:506; Thevathasan 2010) have concluded that women experience post-traumatic disorder in relation to TOP. In addition, Sebola (2014:61), Makutoane (2016:47) and Yuen Loke and Lam (2014:5) revealed in their studies on TOP that participants felt that they have acted contrary to their own moral standards because they viewed TOP as murder or killing.

Adolescents who have either been coerced into falling pregnant and then terminating their pregnancy experience severe guilt that becomes an overarching psychological problem (Silverman, McCauley, Decker, Miller, Reed & Raj 2011:60). The guilt experienced is a result of internalised blame because the women feel that they failed to protect their unborn babies (Sebola 2014:12). Research (Fergusson, Horwood & Ridder 2006:16; Thevathasan 2010; Rausset et al 2011) found that this guilt may lead women to make self-defeating decisions such as a resolution never to have a child.

Guilt is the emotion associated with the perception of wrongdoing by violating an important social, moral or ethical rule as well as following loss or a traumatic experience (Chaplin 1975) as cited by (Nader 2016:1). High levels of guilt have been strongly linked to psychopathology (Rangganadhan & Todoroy 2010:3) and to a combination of tension, remorse, anxiety, and regret. Through self-forgiveness, self-resentment and guilt emotions triggered by TOP can be consciously overcome in order to reach internal acceptance of self. The resolution of this self-conscious emotion, according to Tangney, Boone and Dearing, (2005 as cited by Rangganadhan & Todoroy 2010:3) is intimately linked to self-forgiveness and finding closure.

## 1.2 STATEMENT OF THE RESEARCH PROBLEM

Termination of pregnancy is an event permeated with personal and social conflicts. The socio-ecological model shows that TOP is multifaceted and has individual, relationship, community, and societal factors that may be contributors to the immense guilt

experienced by adolescents after terminating a pregnancy and their inability to forgive themselves.

The Choice of Termination of Pregnancy Act of 1996 provides for a non-compulsory and non-prescriptive counselling before and after TOP. The permission aspect of the Act forms part of the pre-termination counselling and determine that only the pregnant woman's permission is essential. However, a contradiction in literature occurs where pre-and post-counselling are regarded as essential for the well-being of the teen mother. However, owing to shortage of health care professionals in most TOP clinics, counselling is not always adequate and at times not done altogether (Hlalele 2008:10). Even where it is done, it does not take cognisance of the fact that TOP is an event with many factors such as relationship factors, the community and the society in which they live as shown in the ecological model for the study. Therefore, it is important that a conceptual model of self-forgiveness be developed to enhance counselling practices by health care professionals.

In the previous study undertaken by the researcher (Sebola 2014), it was found that adolescents who terminated pregnancy may feel so much guilt that they either terminate all their future pregnancies or they immediately fall pregnant in order to replace the child that they aborted. Adolescents' belief that TOP is murder intensifies their guilt, even though some were coerced into terminating their pregnancies. In that context, they were powerless to defend themselves and their unborn babies. Reproductive coercion among adolescents was found to be associated with unintended pregnancies and pregnancy outcomes (Park, Nordstrom, Weber, Irwin 2016:74; McCauley et al 2014:123). Consequently, guilt experienced by women who have been coerced into terminating their pregnancies can be so intense that it may even lead to some psychological problems (UNFPA 2005; UNICEF 2011). The researcher proposes to develop a model of self-forgiveness that will be used during counselling intervention for women who terminated pregnancy in adolescence.

## 1.3 SIGNIFICANCE OF THE STUDY

Participants' meanings of TOP will lead to the development of a conceptual model of self-forgiveness. Pregnancy in adolescence is a concern for many countries including

South Africa (where the study was conducted) and such a model will have implications for nursing practice, nursing education curriculum and health care policy.

The Choice of Termination of Pregnancy Act of 1966 provides for a non-compulsory and non-prescriptive counselling. Owing to the shortage of health care professionals in most TOP clinics, counselling is not always adequate and at times not done altogether (Hlalele 2008:10). Even when it is done, it does not take cognisance of the fact that TOP is an event with many factors such as relationship factors, the community and the society in which they live as shown in the social ecological model for the study. Therefore, it is important that a model of self-forgiveness be developed to enhance counselling practices by health care professionals.

Prevention of unwanted or unplanned pregnancy among adolescents is critical and nurses are in a position to engage in primary prevention. Before any harm has been done, secondary prevention (i.e. case finding and interventions to interrupt when the sequelae of trauma for example, RC, have occurred) and tertiary prevention that will be instituted when the sequelae of trauma has occurred (for example, RC, IPV or feeling guilty about TOP) in order to reduce their impact. As a result, the inclusion of the conceptual model of self-forgiveness in counselling or in the curricula for nurse training will have implications for nursing practice.

According to the South African Choice on Termination of Pregnancy Act (Act 92 of 1996), the state is obliged to promote the provision of non-mandatory and non-directive counselling before and after TOP (Boezaart 2010:25). This is provided because TOP can cause physical and psychological problems. Therefore, Choice on Termination of Pregnancy Act (Act 92 of 1996) needs to give mandatory guidance on counselling, with the possible inclusion of self-forgiveness.

The findings of a study on reproductive coercion and unintended pregnancy among female family planning clients by Miller, McCauley, Tancredi, Decker, Anderson and Silverman (2014:124) revealed that more young women report RC as compared to older women, underscoring the need to include education for RC in adolescent pregnancy prevention efforts. Therefore, this study will highlight the importance of clinics providing reproductive health services as sites for identification, assessment and interventions for

young women to reduce harm related to IPV and to RC. Moreover, these clinical settings can serve as a connection to victim services to support women exposed to violence as well as a site for prevention education about IPV and RC and harm reduction strategies to increase women's safety and reduce pregnancy risk.

Raising awareness about the association of RC with unintended pregnancy may have implications for the health policy to facilitate addressing barriers to contraception use among adolescents in order to reduce their elevated risk for unintended pregnancy and its repercussions. Public awareness regarding reproductive coercion, guilt after TOP as well as self-forgiveness will help create a supportive rather than a judgemental social environment about TOP.

By using the social ecological-model approach, with its emphasis on systems, there will be a shift from a focus on single and linear causality of psychological problems following TOP towards a holistic concern to develop supportive contexts in the places where these women live their lives. The social ecological model promotes an understanding of the relationships associated with behavioural change and will be applied to facilitate the inclusion of self-forgiveness when caring for or counselling women laden with guilt after TOP.

This study highlighted the relationship of reproductive coercion to teenage pregnancy and subsequent TOP. Raising awareness about reproductive coercion and TOP, especially with the Department of Basic Education (DBE) including the Department of Higher Education and Training developing programmes to deal with it, will prevent unwanted pregnancies and reduce the rate of TOP.

## 1.4 MOTIVATION OF THE STUDY

TOP is a procedure performed in a clinic or outside the hospital to end a pregnancy, from the 13th up to the 20th week of gestation (Boezart 2010:24). In South Africa, it is legalised through The Choice on Termination of Pregnancy Act (Act 92 of 1996) (Boezart 2010:24).

TOP is shrouded in secrecy owing to the fear of judgement and stigma surrounding it. This situation augments feelings of distress already affecting women who do not have

support in the decision-making process about their pregnancy. Women who terminated pregnancy find it emotionally difficult if they do not get support from their partners. Their lack of support can be followed by negative psychological outcomes, including guilt feelings about their TOP.

Unwanted pregnancy is the major cause for choice of TOP for many adolescents. Adolescents are more susceptible to unwanted pregnancies. Research that reveals that unintended pregnancy is related to reproductive coercion is emerging and that the phenomenon occurs mostly for women in violent relationships.

Not much has been researched about the relationship of reproductive coercion, TOP, and psychological problems experienced by women after TOP, especially guilt. As a result, there is a need for research in this area, as well as in self-forgiveness as a strategy to address the guilt felt by women after TOP.

## 1.5 DEFINITIONS

### 1.5.1 Adolescence

Adolescence is a transitional period of humans between childhood and adulthood. According to Weiten (2013:433), its age boundaries are not exact but it is generally accepted to begin around the age of 13 and end at about age 21-22. It is noted that adolescence age is not universal across cultures, with some societies having young people moving directly from childhood to adulthood (Larson & Wilson 2004; Schlegel & Barry 1991).

United Nations Population Fund (UNFPA) along with the World Health Organization (WHO) and United Nations Children Fund (UNICEF) define adolescence to be between the ages of 10-19. The UNFPA further classifies it as early adolescence for the ages 10-14 years and late adolescence for the ages 15-19. The South African National Adolescent Sexual and Reproductive Health and Rights Framework Strategy of 2014-2019 aligns itself with the category of 10 -19, as well as embracing the breakdown of this category for age – appropriate SRHR interventions and education (National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019, 2015:17).

Adolescence is marked by the onset of maturation of sexual functions in both males and females. The prefrontal cerebral cortex, a part of the brain which is crucial to high-level cognitive functions such as planning, organising, emotional regulation, and response inhibition (Casey, Tottenham, Listen & Durston 2005 as cited by Weiten 2013:435) is not yet fully mature until their mid-20's. Theorists suggest that the immaturity of the prefrontal cortex explains why risky behaviour peaks during adolescence and then declines in adulthood (Weiten 2003:435). This risky behaviour during adolescence could also be related to peer influence.

### 1.5.2 Adolescent

These are young people of a certain age bracket. Different scholars refer to varying ages. Although its age boundaries are not exact, Weiten (2013:433) notes that it is generally accepted to begin around the age of 13 and ends at about age 21-22. According to the South African National Adolescent Sexual and Reproductive Health and Rights Framework Strategy of 2014-2019, an adolescent falls within the ages of 10-19 (National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019, 2015: 17).

On the contrary, Letsapa (2010:6) defines adolescents as people from the age of 14 to 24. The current study considered individuals who were born during the period 1982-1997. Retrospectively, these women fell between the ages of 20-35 years. Those born earlier than 1982 are now adults and may not have remembered their adolescence time and experiences.

In this study, an adolescent is a person who is developing from childhood into adulthood (Weiten 2013:433), aged 10 to 19 years and has terminated pregnancy at a TOP clinic.

### 1.5.3 Termination of pregnancy

TOP is a procedure performed in a clinic to end pregnancy from the thirteenth up to the twentieth week of gestation (Boezart 2010:24) amongst adolescents (10-19 years old). In South Africa, it is legalised through The Choice on Termination of Pregnancy Act (Act 92 of 1996) (Boezart 2010:24).

### 1.5.4 Guilt

Guilt is the emotion associated with the perception of wrongdoing by violating an important social, moral or ethical rule as well as following loss or a traumatic experience (Chaplin 1975 as cited by Nader 2016:1). It is also seen as the condition or fact of having committed a crime (Hornby 1998:529) or an offence. Guilt arises from the moral component of personality that incorporates social standards about what represents right and wrong or good and bad. As a person matures, many social norms regarding morality are eventually internalised. These norms may become irrationally demanding in striving for moral perfection and as a result, the person may be plagued by excessive feelings of guilt (Weiten 2013:458). Self-blame and depression are related to feelings of guilt. According to Nolen-Hoeksema and Hilt (2011), the prevalence of depression is about twice as high in women as it is in men. According to Nolen-Hoeksema and Hilt in Gotlib and Hammen (2009:386), this is owing to the fact that women have a greater tendency than men to meditate about setbacks and problems among others. This tendency to dwell on one's difficulties elevates women's vulnerability to depression and feelings of guilt. For this study, the offence or immorality is the aborting of a pregnancy by choice.

### 1.5.5 Self-forgiveness

Self-forgiveness has been framed as a process that helps to facilitate psychological as well as physiological well-being following wrongdoing (Wohl & McLaughlin 2014:422). It alleviates negative feelings related to acknowledged, on-going, wrongful behaviour committed by self. Moreover, women who committed abortion feel that they acted in a way that caused harm to the foetus and to themselves. These negative emotions can be reduced or eliminated through self-forgiveness because it causes release of self-directed negative feelings and replaces them with self-respect and goodwill (Dillon 2001:53). Therefore, acknowledgement of wrong committed by self as well as attempts to repair the damage are essential components of self-forgiveness.

#### *1.5.5.1 Self-forgiveness as a facilitator of health and well-being*

From a psychological understanding, a large body of research has demonstrated

that forgiveness by a victim towards the perpetrator results in the betterment of the victim's psychological and physiological well-being (for example, decreased blood pressure, increased life satisfaction), post-transgression relationship functioning, reduction of the likelihood to re-offence and benefits of mental and physical health (Wohl & McLaughlin 2014:424).

A great deal of empirical research supports this optimistic understanding. In their study, Scherer, Worthington, Hook and Campana (2011:1) argue that self-forgiveness has been used with success on participants who were undergoing routine alcohol treatment. Participants who completed the self-forgiveness intervention reported more positive gains on measures of self-forgiveness, drinking refusal self-efficacy as well as guilt and shame linked to alcohol-related offences. The ability to self-forgive was also found to be positively related to feelings of self-worth in post-divorce couples that were adjusting to divorce (Wohl & McLaughlin 2014:424).

It follows that techniques of self-forgiveness have been applied to a variety of psychological therapies to some success, therefore giving the impression that self-forgiveness training can improve the health and well-being of adolescents and young adults who are experiencing mental problems related to guilt and survivor guilt. Nevertheless, research shows that there are limits and boundaries to the benefits of self-forgiveness.

#### *1.5.5.2 Self-forgiveness as a hindrance to health and well-being*

For on-going negative behaviours, being granted forgiveness appears to provide the offender the licence to reoffend (Wohl & McLaughlin 2014:425). Similarly, self-forgiveness for on-going, negative behaviours helps to maintain the behavioural status quo. Wohl and McLaughlin (2014:425) observed that the more people forgive themselves, the less likely they are to stop their harmful behaviour. On the other hand, it has been found that readiness to change among disordered gamblers increased to the extent that they were relatively unforgiving of their gambling behaviour (Squires, Sztainert, Gillen, Caouette & Wohl 2012), as cited in Cornish and Wade (2015:101). The same researchers found that self-forgiveness for infidelity led to a greater willingness to engage in infidelity. It therefore follows that

the offering of self-forgiveness can promote negative outcomes in some individuals. It also does not work for people who believe that they have unchangeable, fixed internal characteristics.

#### *1.5.5.3 Pseudo-self-forgiveness*

Self-forgiveness where the wrongdoer correctly accepts full responsibility for an offence and self-forgives is considered true and genuine (Holmgren 1998). Pseudo self-forgiveness occurs in situations where the wrongdoer is 100% responsible but tries to shirk some responsibility by incorporating an external attribution into the explanation for wrongdoing. According to Wohl and McLaughlin (2014:427), this shifting of responsibility to an external element that should instead be attributed to self, coupled with self-acceptance, is pseudo-self-forgiveness. There is need to assess the woman for readiness to genuinely self-forgive before engaging in a session of self-forgiveness.

### 1.5.6 Social ecological model

Social ecological models are visual depictions of dynamic relationships among individuals, groups and environments. They derive from a systems approach to human development, in which individuals are understood to influence and be influenced by people and organisations with whom they interact, available resources and institutions, and societal norms, rules, and beliefs (Bronfenbrenner, 1992). In the health promotion fields, ecological models have been used to understand and to identify targets for both general and specific health behaviour interventions (Golden, McLeroy, Green, Earp & Lieberman 2015:10).

In this study, social ecological model was used in guiding conceptual understanding of the experiences of women who had unwanted pregnancies or who terminated their pregnancies during adolescence, develop research questions, select data collection strategies, and interpret the findings. Using this model offers a holistic framework for seeing interrelationships (Higgins, Begoray & MacDonald 2009:352). Therefore, the social- ecological model was also used for this study to advance understanding and shaping the use of self-forgiveness on women who are laden with guilt after TOP. Such a model will assist with recognising internal and external influences.

The Social ecological model sees several levels of influence. Grabbe, Ball and Hall (2016:240) explain these levels as follows:

- **The individual factors**

This includes personality traits and the level of education for women who terminated pregnancy in adolescence.

- **Relationships factors**

For the purpose of this study, relationship factors will include all those that played a role in either reproductive coercion in adolescents such as partners, parents and or interacted directly with the woman before and after TOP, for example, churches and schools.

- **Community factors**

Community factors include health care institutions, neighbourhoods and other community organisations dealing with young adult women.

- **Society factors**

These include the public and policy makers, the laws of the country, the ability of the community to give support as well as stigmatisation about TOP.

### 1.5.7 Strategy

Self-forgiving strategies for people who have undergone TOP during adolescence are generally defined as planned activities designed to achieve psychological benefits of self-forgiveness on women who suffer guilt and/or survivor guilt after TOP by choice.

### 1.5.8 Narrative

A narrative, sometimes known as a story, is used in qualitative research to understand the meaning that participants ascribe to their experiences. In storytelling, knowing about an experience is transformed into telling. The main claim for the use of narrative in qualitative research, according to Connelly and Clandin (1999:2) is that humans are storytelling organisms who individually and socially lead storied lives. Individuals are storytellers and characters in their own and others' stories. Narrative researchers in turn describe such storied lives, collect and tell stories of them and write narratives of experience.

The narrative involves the narrator's performance to the researcher-as-audience and incorporates how the performance is viewed and interpreted. Narration is an activity that captures a narrator's interpretation of a link among elements of the past, present and future at a fleeting moment in time (Sandelowski 1991:162). It focuses on story as the object of inquiry in order to understand how individuals make sense of events in their lives, that is, to understand how participants express the reality of what actually happened in their lives, how they experienced what happened and how they relate their stories (Sandelowski 1991:161) .

Telling the story of their experience allows participants to most effectively make sense of their world and to reflect on the experience from their own point of view, to inform others about the experience. Both the participant and the researcher derive meanings related to the experience (Polit & Beck 2014:274).

To facilitate the story to be told, a narrative interview is suggested. It is important to use an unstructured format that will enable the personal narrative to emerge. More importantly, asking the right questions requires the use of an interview guide consisting of five to seven broad questions (Watson, Benner & Ketefian 2008:335).

In this study, the researcher, using an interview guide, asked relevant questions to participants as they narrated their stories in order to enable the personal narrative to emerge. A core value of narrative is that it provides a lens through which to explore the complexities and plot the relationships between selfhood, identity and the social world

(Watson, Benner & Ketefian 2008:332). In addition, Polit and Beck (2014:274) further explain that individuals construct stories when they need to understand situations that require linking an inner world of desire to an external world of observable actions. It examines the interaction between past and present construction of self, and at its core is concerned with uncovering the perspective on the life course through the performance of a narrative (Watson, Benner & Ketefian 2008:332).

According to Burke (1969) as cited by Polit and Beck (2014:274), several structural approaches can be used to analyse stories. Burke's (1969) pedantic dramatism is one such approach consisting of the following key elements: act, scene, agent, agency, and purpose. Somers (1994 as cited by Watson, Benner & Ketefian 2008:333), highlight the relational aspects of narratives as consisting of the person's own inner world, the social context, the broad cultural and historical context and the researcher's frame of reference. Narrators provide structure to the stories they tell but researchers impose and seek plots and there is a tendency of narrative work to arrange events and the structure of a life in a coherent order.

The following key elements that provide form to narratives are identified by Riessman (1993 as cited by Watson, Benner & Ketefian 2008: 335):

- Structure, which includes starting point, an abstract, orientation (time, place, situation, and participants), complicating action, evaluation, resolution and coda (return to the present).
- Plot, which frames the narrator's sense of meaning, and these vary from tragedy, comedy, romance, satire and so act as arch types and points of reference.
- Agency and truth, which is the degree of truth attached to the narrative reflects the researcher's perspective. In this study the researcher took note of the different key essentials that gave form to narratives as they unfolded.

### 1.5.9 Termination of pregnancy (TOP)

TOP, also referred to as abortion, means the removal of a foetus from the uterus before it is mature enough to live on its own (International Planned Parenthood Federation [IPPF] 2008). TOP may be induced (voluntarily performed) or spontaneous (IPPF 2008). Unsafe and illegal abortions are claiming many women's lives, especially in developing

countries where the rates of unsafe pregnancy terminations seemingly do not change (IPPF 2008). Responsible sexual behaviour, including voluntary sexual abstinence need to be promoted and included in the education and information programmes in order to minimise the need for TOP (IPPF 2008).

The United Nations (UN), through its agency for population and reproductive health, the United Nations Population Fund (UNFPA), warns that it has never promoted and does not promote TOP as a method of family planning (UNFPA 2005). The UNPFA further postulates that the UN's position has always been that every attempt should be made to eliminate the need for TOP. Paragraph 8.35 of the 1994 International Conference on Population Development (ICPD) Programme of Action (PoA) stipulates the following:

- The status of a country's population policy, including the legal status of abortions, is the sovereign right of each nation.
- An unsafe abortion is a serious public health concern, hence prevention of unwanted pregnancies must always be given the highest priority (UN 1994).

The UNPFA has called for countries to obey the prescriptions of the 1994 International Conference on Population and Development Programme of Action (UNPFA 2006). Emphasising the issue of abortion, the UNPFA (2005) commits to supporting governments to strengthen their national health systems to prevent the abortions and to ensure that the management of complications from the TOP are part of reproductive health, family planning, and sexual health programmes, thereby saving women's lives. Nevertheless, the UN acknowledges that while it emphasises that countries should take every measure to prevent unplanned pregnancies, pregnancies could still result from an unmet need and contraceptive failure, resulting in unwanted pregnancy and a need for its termination (UNPFA 2005).

In South Africa, TOP is legalised through The Choice on Termination of Pregnancy Act (Act 92 of 1996), which took effect in 1997 (Boezart 2010:24). The Choice on Termination of Pregnancy Act (1996) suggests that a woman of any age who is eligible for an abortion can be provided with TOP upon request, even without giving reasons, provided that she is less than 13 weeks pregnant (Boezart 2010: 24). According to Boezart (2010: 24), a woman who is more than 20 weeks pregnant can have TOP services provided only if her life is or the life of the foetus is at stake or if the foetus is

likely to have serious birth defects. The 1996 Choice on Termination of Pregnancy Act further stipulates that eligibility for the abortion further includes the gestational status of between 13 and 20 weeks, provided that:

- The woman's physical or mental health is at stake.
- The unborn baby will have severe mental or physical abnormalities.
- Pregnancy resulted from incest or rape.
- The woman's economic or social situation (health professionals may advise a parents; however, the ultimate decision to consult or inform will be hers).

The Choice on Termination of Pregnancy Act (1996) further postulates that health facilities that have 24-hour maternity services are eligible to perform TOP with pregnancies of up to and including 12 weeks without having to obtain an approval of the Member of the Executive Council (MEC), provided the provisions of the Act (1996) have been complied with. Provision of pre- and post-abortion counselling is not mandatory. Nevertheless, as Mmusi-Phetoe (2011:37) notes, most abortion centres do provide counselling.

TOP has been linked to a number of physical and psychological problems (Blum & Nelson-Mmari 2004:402). Adolescents who have been coerced into falling pregnant and then terminating their pregnancy, experience severe guilt and this guilt becomes an overarching psychological problem (Silverman et al 2011:60), sometimes carried into adulthood.

### 1.5.10 Reproductive coercion (RC)

RC is a type of intimate partner violence (IPV) that involves exerting power and control over contraceptive and/or pregnancy choices and outcomes (Park et al 2016:74). It can occur in conjunction with or independent of physical or sexual violence. On the contrary, it refers to the male partner pregnancy-controlling behaviours. According to Miller and Silverman (2010:152), male partner RC is defined specifically as male partner's attempts to promote pregnancy in their female partners through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes).

Miller, McCauley, Tancredi, Levenson, Waldman, Schoenwald, and Silverman (2014:123) accentuate that RC is used to define a range of male partner pregnancy-controlling behaviours. These behaviours can include birth control sabotage, threats and use of physical violence if a woman insists on contraception, emotional blackmail, coercing a woman to have sex or to fall pregnant, or to have an abortion as a sign of her love and fidelity as well as forced sex and rape.

In these circumstances, pregnancy can be used as a tool of control and a sign to a perpetrator that they have power over their partner's body. In addition, RC is an easy, effective and cowardly way of manipulating and controlling a woman by limiting her autonomy over her fertility and reproductive health and choices. Among others, women can experience coercion from a partner to become pregnant, to progress with a pregnancy she does not want or to terminate a pregnancy she wishes to continue. It usually occurs within the context of relationships that are violent in other ways, as an additional tool used by perpetrators of violence (Miller et al 2014:122).

Abusive male partners have been found to actively promote pregnancy through behaviours spanning verbal pressure to become pregnant, condom manipulation, threats or actual violence in response to condom requests and direct acts of birth control sabotage (for example, removing a vaginal ring, throwing out birth-control pills and blocking women from seeking access to contraception). In addition, once their female partner is pregnant, abusive male partners may enact behaviours to control the outcomes of the pregnancy, including violent acts to attempt to induce miscarriage and coercion to either continue or terminate the pregnancy.

While women may also attempt to control the outcome of their pregnancies, without their partners' knowledge, the focus here is on how male partners' abusive behaviours may be connected to unintended pregnancy and eventually TOP.

Studies by Miller and Silverman (2010) indicate that there is a link between unintended pregnancy and IPV.

### 1.5.11 Unintended pregnancy

Unintended pregnancy is defined broadly as pregnancy that was not planned, was unexpected or mistimed or not wanted by a woman. It is common and disproportionately affects younger women (Miller et al 2014:122).

Being victimised by an intimate partner through physical and sexual violence is associated with poor reproductive health, including unplanned pregnancies, poor pregnancy outcome, among others. Unintended pregnancies are two to three times more likely to be associated with intimate partner violence (IPV) than planned pregnancies. Mechanisms linking IPV with unintended pregnancy include women's compromised sexual decision-making (McFarlane, Malecha, Watson, Gist, Batten & Hall 2005 as cited by Miller et al 2014:2), limited ability to enact contraceptive use, inconsistent condom use and fear to negotiating condom and contraceptive use (Miller et al 2014:122). Forced sex and partner interference with access to healthcare all contribute to this association between unintended pregnancy and intimate partner violence (Miller & Silverman 2010:511) and TOP.

## 1.6 RESEARCH AIM/PURPOSE, OBJECTIVES AND QUESTIONS

### 1.6.1 Research purpose

The purpose of this qualitative study was to develop a model of self-forgiveness for women who terminated pregnancy in adolescence.

### 1.6.2 Research objectives

The objectives of this study are mentioned according to phases as in Table 1.1.

**Table 1.1 Objectives according to phases**

| Phase | Objective |
|---|---|
| 1 Desktop review | Explore what is already known in literature about reproductive coercion, guilt and self-forgiveness. |
| 2 Lived experiences | Investigate lived experiences of women who have terminated pregnancy in adolescence. |
| 3 Develop a model of self-forgiveness | Incorporate gaps identified in the existing literature and findings from the study to develop an appropriate self-forgiveness model |

### 1.6.3 Research questions

Based on these objectives, the study answered the following questions:

- What are the lived experiences of women who had terminated pregnancy in adolescence?
- What is already known in literature about reproductive coercion, guilt and self-forgiveness?
- What gaps related to self-forgiveness have been identified in the literature?
- How do the sub-systems of the social ecological environment influence women who terminated pregnancy and feel guilty about it?

## 1.7 THEORETICAL FRAMEWORK

The social ecological model underpinned this study (Higgins et al 2009:352). Social ecological models are visual depictions of dynamic relationships among individuals, groups and environments. They derive from a systems approach to human development, in which individuals are understood to influence and be influenced by people and organisations with whom they interact, available resources and institutions, societal norms, rules, and beliefs (Bronfenbrenner 1992). In the current study, the ecological model was used to understand and identify targets for health behaviour interventions (Golden et al 2015:11).

The model was used to describe the experiences and behaviours of individual women situated within environmental sub-systems and forces as well as propose a framework of processes and social conditions that will facilitate health-promoting social policy and environments. Through this model, the researcher conceptualised ways in which individual women, their social networks, and organised groups produce a community context that can foster healthful policy and environmental development.

Introducing self-forgiveness as a strategy of dealing with guilt among women who terminated pregnancy looks like an individual choice at first. However, understanding it requires looking beyond an individual. The social ecological model recognised the interaction among individual women, groups and their proximal and distal social environments. Given this understanding, the best theoretical stance to explain the experiences of women who terminated pregnancy and change in their health was a social ecological one, that is, a model that included individual and group interrelationships in a broad social network or ecology. Using this model offered a holistic framework for seeing interrelationships (Higgins et al 2009:352). This model was also useful in advancing understanding and shaping the use of self-forgiveness on women who are laden with guilt following TOP. The social ecological model assisted with recognising internal and external influences on these women. It also identified several levels of influence. Grabbe et al (2016:240) define these levels as the individual, relationships, community, and society factors.

- **The individual factors**

These include personality traits and the level of education for women who terminated pregnancy in adolescence.

- **Relationships factors**

For the purpose of this study, relationship factors included all those that played a role in either reproductive coercion in adolescents such as partners, parents, friends, peers and the church.

- **Community factors**

Community factors included health care institutions, schools, neighbourhoods, and other community organisations interacting with young adult women.

- **Society factors**

These included public and policy makers, the laws of the country, and the ability of the community to give support as well as stigmatisation about TOP.

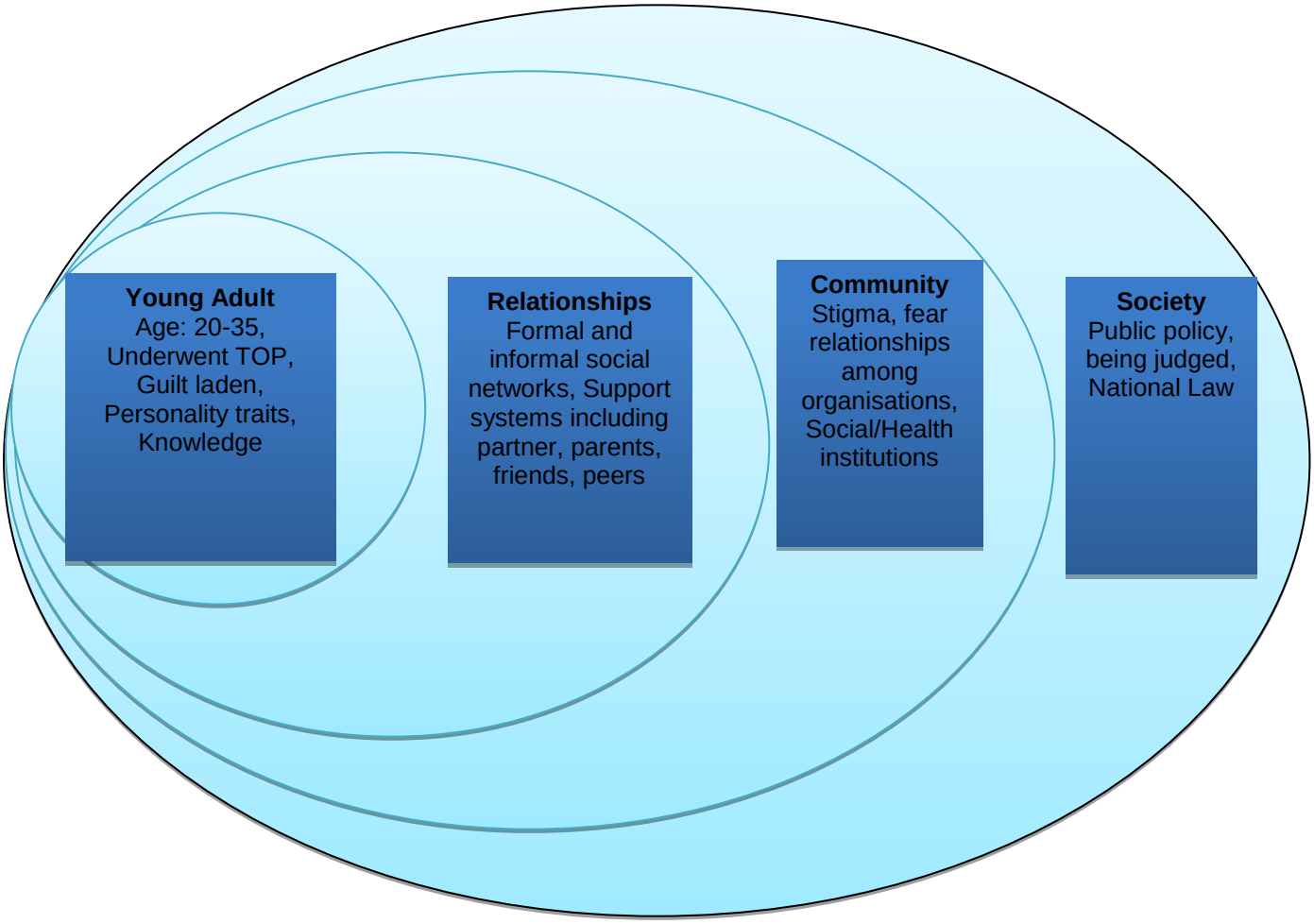



**Figure 1.1 Levels of guilt on the Social-Ecological Model: A framework for self-forgiveness**

(Grabbe et al 2016:240)

Developed by the researcher from literature review and conceptual model used

### 1.7.1 Young adults

The main focus of the study is on young adults aged between 20-35 years of age. The age group was chosen because they are still on the childbearing age and would remember the reasons behind terminating pregnancy in adolescence. The study also assessed whether participants were coerced to become pregnant or to terminate pregnancy and whether they felt guilty after terminating pregnancy in adolescence. Personality traits that could be associated with the need to terminate pregnancy were also assessed, as well as guilt after terminating pregnancy and the willingness to accept or fail to accept self-forgiveness and if they were knowledgeable enough to make such a decision. Developmentally, adolescents have not yet fully acquired the competencies necessary for adult roles, such as problem solving and decision-making skills (Hlalele 2008:9). This is because the prefrontal cortex of their brain is still not yet fully developed. The cortex is characterised as the control centre of the brain, 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).

Factors of the social ecological framework for guilt after TOP at individual level were prompters for self-forgiveness strategies to effect emotional changes on women who terminated pregnancy by choice during adolescence.

### 1.7.2 Relationships

Relationships level focused on formal and informal social networks, support systems including partner, parents, friends and peers that women directly interacted with from adolescence and how social support or lack of social support impacted on their decision making as well as their psychological health after TOP. These were chosen because young women need the support of their partners, of parents especially the mother, of friends or peers. At the same time, adolescents turn to friends and peers for advice on matters they fear discussing with parents or teachers. Adolescents expect support from their partners when they fall pregnant or intend terminating a pregnancy. Lack on this support can have consequences for their mental health.

The study enquired about the nature of their relationships with their significant others during pregnancy; before and after TOP; their source of information about pregnancy and TOP; whether they received support or not during pregnancy and about TOP; the meaning of support or lack of it; to whom they disclosed about TOP and whether they felt judged or not.

The factors stated were prompters for intervention strategies to effect behavioural changes at this level.

### 1.7.3 Community

The focus of the study regarding community was on reproductive coercion, stigma about teenage pregnancy and TOP. These also include the fears that these challenges induced on teenagers who seek TOP, the relationships between organisations specifically health institutions, schools, tertiary institutions, youth clubs and religious institutions. Furthermore, this also affected the teenagers' relationships with the media, the law enforcement organisations, the private sector or any organisation involved in human service as well as the cultural beliefs and customs of the community in which the woman exists. Therefore, these factors have an indirect but profound influence on the women who terminated pregnancy.

The magnitude of RC, teenage pregnancy and TOP by adolescents calls for transcending the traditional boundaries of health and human service. The judgemental attitude of the community towards teen pregnancy and TOP causes stigmatisation about these events, such that instead of seeking help or support, the teenager fears being judged by the community.

The different organisations were targets for education on the relationship of RC, teenage pregnancy and TOP as well as guilt and self-forgiveness. The study assessed relationships that these women had with TOP clinic staff, their teachers, religious leaders or youth leaders during pregnancy and after TOP.

### 1.7.4 Society

The effects of the principles defined at societal level have influence on the interactions of all other layers of the model. The focus at societal level was on public policy, the national laws and the society - its cultural beliefs and customs as well as the media. The attitude of the society towards TOP and teenage pregnancy can be changed, RC can be prevented and the society can be made aware of the psychological impact of TOP on women and the use of self-forgiveness as a counselling strategy on women who feel guilty about TOP. To achieve this required the engagement of the public and policy makers. The study raised these recommendations.

The study reviewed the Choice on Termination of Pregnancy Act of South Africa as well as the documents pertinent to TOP, including the care of women after TOP. The Choice on Termination of Pregnancy Act was targeted for recommendations regarding the content of pre and post TOP counselling. The strategy of the National Policy on the Prevention and Management of Learner Pregnancy (Pretoria News 29/03/2007: 3) introduced by the Minister of Basic Education in South Africa was also assessed for any gaps. The media, including television, were also recommended to be targeted for raising awareness about RC, guilt as related to TOP and self-forgiveness.

## 1.8 RESEARCH METHODOLOGY

This was a three-phase study that used a qualitative approach. A qualitative approach was used to explore experiences, meanings, perceptions, and feelings (Kumar 2011:20) about the phenomenon, its exploration and description of experiences is in-depth (Botma, Greef, Mulaudzi & Wright 2010:211).

In the present study, the qualitative researcher was concerned with understanding the experiences, rather than explanation, with naturalistic observation rather than controlled measurements, and with the subjective exploration of the reality of TOP from the perspective the participants (De Vos, Strydom, Fouché & Delport 2012:308). More importantly, the use of a qualitative approach enabled the researcher to explore guilt and shame, in an in-depth and holistic fashion, among women who terminated pregnancy during adolescence, as well as their need to forgive themselves.

## 1.9 TRUSTWORTHINESS

Trustworthiness is the degree of confidence that qualitative researchers have in their data. Accordingly, in this study, it was assessed using the criteria of credibility, transferability, dependability, and conformability (Botma et al 2010:32).

These measures were undertaken to ensure rigour.

### 1.9.1 Credibility/authenticity

Credibility is a criterion for evaluating integrity and quality in qualitative studies (Polit & Beck 2014:378). De Vos et al (2012:419) accentuate 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. The following strategies helped to increase the credibility of this study:

#### *1.9.1.1 Prolonged engagement and persistent observation in the field*

Polit and Beck (2014:542) assert that prolonged engagement is the investment of sufficient time collecting data in order to have in-depth understanding of the culture, language or views of the people and to ensure data saturation of important categories. In the present study, through persistent observation, high quality data was collected. Prolonged engagement provided scope and persistent observation provided depth.

#### *1.9.1.2 Triangulation of different methods*

Triangulation of different methods involves using multiple methods of data collection about the same phenomenon (Polit & Beck 2014:393). In this study, the researcher undertook tape-recorded narratives and interviews as well as written field notes.

#### *1.9.1.3 Peer review and debriefing (group discussions)*

Peer review involves sessions with peers to review and explore various aspects of the enquiry (Polit & Beck 2014:387). 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 narratives and interviews to peer debriefers and to the supervisor of this study, including an expert in qualitative research at the University of South Africa (Unisa). Therefore, peer review and debriefing were used to enhance accuracy of the account and for objective assessment of the study.

#### *1.9.1.4 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 (Botma et al 2010:231). It is also carried out in order to verify if the results reflect participants' realities. Member checking was done throughout the study and after data collection, to allow participants opportunities to scrutinise the researcher's interpretations.

#### *1.9.1.5 Formalised qualitative methods such as analytic induction*

The researcher collected data about rich descriptions from the participants regarding their experiences of TOP. For the purpose of this study, an interpretive approach, which is also called a phenomenological approach, guided the researcher (De Vos et al 2012:8).

### 1.9.2 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 2014:393) so as to generalise to larger populations (Botma et al 2010:233). In this study, even though the researcher did not specifically aim for generalisability, she wanted to generate knowledge that would be useful in other situations. Accordingly, the researcher used a nominal sample and very informative descriptions of data in the

research report so that readers of the report could evaluate the applicability of the data to other contexts.

### 1.9.3 Dependability

Polit and Beck (2014:323), describe dependability of qualitative data as the stability or reliability of data over time and over conditions. That is, findings will be consistent if the inquiry was replicated with the same or similar participants and in a similar context. The findings of this study were made open for scrutiny by the supervisor of this research. For analysis and interpretation, field notes and transcriptions were also given to an independent coder who did not participate in this study. The independent coder and the researcher met to agree on themes and sub-themes. The researcher strived to stick to the research problem and stay focused.

### 1.9.4 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.

Confirmability refers to objectivity, which means the potential for congruence between two or more independent people about the accuracy of data, its relevance or meaning (Polit & Beck 2014:323). Throughout the research process, the researcher remained sensitive to her own assumptions about TOP so that the data represented the information participants provided and the findings reflected the participants' voice and the conditions of the enquiry and not the researcher's biases, motivations or perspectives. There was no bias related to the interpretation of data because the researcher ensured that the interpretation of those data were not her own imagination.

## 1.10 ETHICAL CONSIDERATIONS

Researchers are expected to observe the value of protecting research participants. Streubert and Carpenter (2011:225) describe ethical considerations in research as

principles that underlie aspects of the mandate to protect research participants from physical, mental and social harm.

For this study, the researcher first sought permissions from different organisations and then adhered to ethical principles as outlined in the Belmont Report (DeLanda 2009).

### 1.10.1 Permissions to conduct the study

In preparation to conduct this study, the researcher first sought and was granted permission by the Research Ethics Committee, Department of Health Studies, Unisa, (refer Annexure A). Permission was later sought and granted by the Department of Health (refer to Annexure C). Lastly, permission was sought and obtained from study participants (refer Annexure D).

Prescribed guidelines of the Department of Health for guiding data gathering required that a full research protocol, including interview guide, consent forms, ethical clearance from a recognised Ethics Committee in South Africa, and letters of support for the study be followed.

### 1.10.2 Ethical principles

There are important ethical issues that should concern researchers during all stages of a research process. Researchers are morally obliged to observe certain ethics in order to safeguard patient's rights (Kumar 2011:242). "Always doing good" (beneficence) and "doing no harm" (non-maleficence) to patients are foundational to effective health service provision.

In preparation to adhere to ethical principles, the following were observed:

#### *1.10.2.1 Informed consent*

An informed consent implies that subjects are made adequately aware of the type of information required from them, why the information is being sought, what purpose it will be put to, how participants are expected to take part in the study, and how the study will directly or indirectly affect them (Kumar 2011:244). For the purpose of this study, the

informed consent included and emphasised the concept of voluntarism and protection of the participants' privacy as well as the participant's decision- making capacity (refer to Annexure D).

When equipped with sufficient information, participants who volunteered to participate in this study were requested to provide signed informed consent. Consent forms were explained in Setswana (the local language), for those participants unable to read English. Study information was read out to those who are unable to read. It was repeatedly stressed to all participants that their decision to participate in the study was voluntary.

#### *1.10.2.2 Beneficence*

Beneficence is an ethical principle that seeks to maximise benefits for study participants and prevent harm (Polit & Beck 2014:375).

To adhere to the principle of beneficence the researcher needs to secure the well-being of the subject, who has the right to protection from discomfort and harm, be it physical, emotional, spiritual, economic, social, or legal (Polit & Beck 2014:375). Botma et al (2010:22) elucidate that risk equates to harm or to injure and implies that it is something detrimental that can happen in the future. For this study, in doing good to the participants, the researcher minimised risks by asking for participants' consent, to avoid dignitary harm, by providing a light snack during story-telling to overcome fatigue, by arranging with the TOP clinic manager to refer participants who experienced intense emotions, by avoiding interviewing participants at their homes and by reimbursing participants money for travelling. The researcher demonstrated respect to participants by having a relaxed facial expression and by not being judgemental.

#### *1.10.2.3 Justice*

The principle of justice is about fair treatment and equality of participants (Botma et al 2010:19). The researcher adhered to the research protocol and information given in the information leaflet. Participants in this study might be defined as vulnerable because people in their lives might have coerced them or circumstances that they were in at the time. More importantly, the researcher ensured that such vulnerability was not in any

way exploited. This was done through emphasising to the participants the freedom to withdraw at any time during the research process and ensuring them of maintaining confidentiality.

#### *1.10.2.4 Confidentiality (non-maleficence)*

Confidentiality is concerned with protection of information. In this study, the following four key areas to confidentiality were maintained: the content of data capturing forms, limited access to data, safe and secure storage of data and the anonymous reporting of data (Botma et al 2010:18).

Data collected were shared only with other researchers. Consent forms with participants' names were separated from other documents. Confidentiality and protection from invasion of privacy were prioritised throughout the study. Caution was taken on dealing with private issues for public knowledge. Each interview session was conducted in a private consulting room allocated to the researcher by the nursing professionals. All forms with information about the participants were stored separately in a secure, locked storage.

#### *1.10.2.5 Autonomy*

Autonomy is concerned with freedom of choice to participate (Kumar 2011:244). To ensure autonomy, participants chose whether or not to participate freely. Any form of coercion was avoided. Where payment or other incentives were offered, there were strict procedures to ensure that participation was by individuals who qualify according to the study protocol. Moreover, disclosure of factual information on details of the study, risks, and benefits was ensured. A written document explaining the purpose of the study and procedure for data collection was developed to ensure consistency of information.

## 1.11 STRUCTURE OF THE THESIS

**Chapter 1: Orientation to the study**

An overview of the study was covered. The overview will cover the introduction, background to the research problem, statement of the research problem, definition of

key concepts used and operationalised in the study. The purpose of the study, study objectives and questions were also discussed. A brief summary of methodology was also given in Chapter 1.

**Chapter 2: Literature review**

The aim of Chapter 2 was to search for related literature on the topic in order to be acquainted with the available body of knowledge in the area of study. Sources including journal articles, reports relevant to the study, grey literature on the topic, laws and regulations related to TOP, books, and dissertations on the related topic were reviewed in order to enable the researcher to situate the study. The chapter elaborated on the connections between reproductive coercion, teenage pregnancy, TOP, and guilt. In addition, self-forgiveness is a process that helps to facilitate psychological as well as physiological well-being was explored.

**Chapter 3: Research methodology**

In Chapter 3, the researcher described the methodology in respect of the research design, data sources, data collection techniques, issues of reliability, and validity as well as the sampling technique.

**Chapter 4: Data analysis and interpretation**

Collected data, the analysis, and its interpretation were presented in Chapter 4. The chapter also detailed ethical considerations as well as pretesting of data generating instruments.

**Chapter 5: Discussion of the findings**

Findings of the study were discussed in Chapter 5 and validated within similar related studies. The gap between the reality of guilt experienced by women who terminated pregnancy during adolescence and how it can be addressed through self-forgiveness was mapped out.

**Chapter 6: Development of a model**

A model that listed the structural determinants of self-forgiveness as well as factors of self-forgiveness outcomes was presented in this chapter.

**Chapter 7: Conclusion, limitations and recommendations**

General study conclusions, limitations of the study and recommendations were given in this chapter. A summary of the findings in terms of the stated research objectives and a discussion of the implications of a model for integrating self-forgiveness into post-TOP counselling in order to eliminate or reduce negative emotions related to TOP were presented.

## 1.12 CONCLUSION

Chapter 1 gave the study‘s orientation and covered the introduction and background which were done in reference to other studies done. It covered the problem statement, significance of the study as well as what motivated the researcher to conduct this study. A socio-ecological model, which guided this study, was also discussed in this chapter, together with issues of trustworthiness and ethical considerations. Chapter 2 will be a desk review, which enabled the researcher to situate the current study and identify any gaps.

# CHAPTER 2

# PHASE 1: DESKTOP REVIEW

## 2.1 INTRODUCTION

Literature is reviewed in order for the researcher to be familiar with what already exists in the area of study. For the purpose of this study, literature review brought clarity and focus to the research problem, improved research methodology, expanded on the knowledge base of the research area and contextualised findings of the research (Kumar 2011:32). More importantly, in the initial stages, the literature review helped to establish the theoretical roots of the study, clarified ideas and developed the research methodology. Later in the process, the literature review helped to improve and consolidate knowledge base about the topic and to integrate findings with the existing body of knowledge.

As noted by Creswell (2014:28), literature search also provides a benchmark for comparing the results of the study with other findings in related studies.

Kumar (2011:32) summarises the functions of literature review as follows:

- Providing a theoretical background to the study.
- Helping establish the links between what the researcher is proposing to examine and what has already been studied.
- Enabling the researcher to show how his findings have contributed to the existing body of knowledge in the profession. It helps to integrate research findings into the existing body of knowledge.

Relevant and up-to-date books, journals and information from the internet were studied critically in order to get together themes and issues that are related to this study. The researcher set limitations by reviewing the literature related to the main themes that are pertinent to the research topic. Accordingly, information obtained from literature was sorted under the main themes and theories. The section will conclude with a discussion

of the lessons learned from the relationships between reproductive coercion, unplanned pregnancy, TOP during adolescence, guilt as well as public policies, highlighting agreements and disagreements among the authors and identifying any gaps. The lessons learned from the literature review as well as from experiences assisted in formulating a conceptual model of self-forgiveness that would enhance counselling practices by health care professionals on women who are laden with guilt, after they terminated pregnancy.

## 2.2 REPRODUCTIVE COERCION (RC)

RC involves behaviour that interferes with contraceptive and pregnancy choices of women and occasionally men (Park et al 2016:74). As a type of IPV, it involves exerting power and control over contraceptives and/or pregnancy choices and outcomes. RC has been found in women (or men) with previous or concurrent history of IPV and mainly among vulnerable populations like adolescents. A growing body of literature on male partner influences on contraception and pregnancy decision-making has identified a range of male partner pregnancy controlling behaviours, which are termed RC.

Male partner RC is defined by Miller and Silverman (2010:511) as male partner's attempts to encourage pregnancy in their female partners through verbal pressure and threats (pregnancy coercion), direct interference with contraception (birth control sabotage), and threats and coercion linked to pregnancy continuation or termination (control of pregnancy outcomes). Practices promoted by abusive partners to actively encourage pregnancy include verbal pressure to become pregnant, condom manipulation, threats or actual violence in response to condom requests and direct acts of birth control sabotage (for example, removing a vaginal ring, throwing out birth control pills and blocking women from seeking access to contraception).

Amazingly, once a female partner is pregnant the abusive male partner may enact behaviours to control the outcomes of the pregnancy including violent acts to induce miscarriage and coercion to either continue or terminate the pregnancy (Miller and Silverman 2010:511). While women may also attempt to become pregnant without their partner's knowledge, the focus here is on how male partner's abusive behaviours may be connected to unintended pregnancy (that is, mistimed, unplanned or unwanted

pregnancy from the woman's perspective) and subsequently coerced TOP by the female partner.

The most common forms of RC include birth control sabotage, pregnancy pressure and pregnancy coercion. According to Park et al (2016:74), birth control sabotage involves any deliberate act that interferes with or inhibits a woman's ability to obtain contraception. Its many manifestations include destroying contraceptive pills, removing vaginal rings, contraceptive patches or intrauterine devices, removing or intentionally breaking condoms or not withdrawing when that was the agreed-upon method of contraception. Pregnancy pressure refers to forcing a female partner to become pregnant when she does not wish to. It includes, among others, threatening to leave or hurting a partner who does not agree to become pregnant (Park et al 2016:74).

On the contrary, pregnancy coercion includes threats or acts of violence if a woman fails to comply with the partner's wishes concerning the decision to terminate or continue an existing pregnancy. It may also include forcing a partner to carry a pregnancy against her wishes or injuring a partner with the intent to cause a miscarriage as well as forcing a partner to terminate a pregnancy against her wishes (Park et al 2016:74).

Unintended pregnancy (defined broadly as pregnancy that was unplanned, was unexpected or mistimed) is common and unduly affects younger women (Miller & Silverman 2010:511). Unintended pregnancies are two to three times more likely to be associated with RC and/or IPV than planned pregnancies and are in turn, according to Guttmacher Institute (2012a:35), the major cause of choice on TOP for many adolescents.

### 2.2.1 Prevalence of reproductive coercion

Park et al (2016:75) note that RC has been shown to affect women from all demographics and is prevalent in both high and low-risk women with adolescents being more susceptible (Decker, Silverman & Raj 2005 as cited in Park et al 2016:75).

Miller and Silverman (2010:512) report that the prevalence of IPV among female clients in the USA ranges from 40% to 53% with one in three experiencing IPV, of which RC is part. Similar to unintended pregnancy, younger women aged 15 to 24 experience the

highest rates (Black, Basile, Breiding, Smith, Walters, Merrick et al (2010) as cited in Park et al 2016:74).

RC by male partners contributes to increased risk for unintended pregnancy and the pressure to terminate pregnancy, amongst others. A cross-sectional survey undertaken in Northern California on more than 1200 women aged 16-29 years, Miller, Decker and McCauley (2010) as cited in Park et al (2016:75) note that 15% reported birth sabotage and 19% reported pregnancy coercion. Three quarters of women who reported a history of RC also admitted being exposed to IPV. The prevalence of IPV in this sample was higher (53%) compared with the national average of 24% reported by the Centres for Disease Control and Prevention. This study revealed a link between IPV and RC.

Moore, Frohwirth and Miller (2010 as cited in Park et al 2016:75) conducted a study in the USA to explore the relationship between IPV and RC with specific reference to post-conception attempts at influencing the outcome of pregnancy (whether aimed at continuing or terminating the pregnancy). The study used a sample of 71 women from a domestic violence shelter, an abortion clinic and a family planning clinic. The study reported that 75% of respondents reported experiencing, amongst others, pregnancy coercive behaviours and attempts at influencing the outcome of pregnancy.

Likewise, in a study of 1,400 surveys done in Pennsylvania, Gee, Mitra, Wan, Chavkin, and Long (2009:148), as cited in Park et al (2016:74) noted that 17% of the women reported not using contraceptives because either their partners were unwilling or wanted the partner to fall pregnant. The prevalence of IPV in this sample was 21% and women were more likely to report RC if they had experienced IPV.

Decker, Miller, McCauley, Tancredi, Anderson, Levenson and Silverman (2014:5) explored the prevalence of IPV and its associations with sexually transmitted infections in Pennsylvania, amongst 3,682, 16-29 year olds seeking care at one of the 24 Title X family planning clinics. They found that recent physical and sexual IPV prevalence was 11%. IPV was related specifically to unprotected vaginal and anal sex, coercive sexual risk, involuntary condom non-use, drug use and fears of requesting condoms and refusing sex. Violence was most prevalent among those aged 16 to 20 (14,4%), among women with less than a high school education (16%) and women who were single or

dating (13,2%). It was evident in this study that the experience of IPV was related to risk behaviour for sexually transmitted diseases or HIV.

Another cross-sectional survey on IPV and RC in the USA, consisting of 1,200 female clients aged 16-29 years in five Northern California Family Planning clinics. The study reported 15% birth control sabotage and 19% pregnancy coercion and three quarter of women who had an RC history also agreed that they experience IPV. The prevalence of IPV in this sample was 53%, compared with the national average of 24% as reported by Centres for Disease Control and Prevention (Park et al 2016:74).

Similarly, in a study of more than 1,400 surveys collected at two planned parenthood centres in Pennsylvania, 17% of the women reported not using contraception because either their partners were unwilling or because their partner wanted the participant to become pregnant. The prevalence of IPV was 21% in this sample and women were more likely to report RC if they had experienced IPV, although it was unclear whether IPV occurred in the same relationship as RC (Park et al 2016:74).

Very few studies have looked at the sexual coercion experiences of adolescents in sub-Saharan Africa. Richter, Mabaso, Ramjith and Norris (2015:306) found that women in this part of Africa commonly experience coercion affecting 15% to 38% of adolescent females. In their descriptive study on voluntary and coerced experiences at sexual debut among adolescents, Richter et al (2015:304) noted that sexual coercion between same age groups and especially among those aged 15-17 years is prevalent in South Africa. This study also revealed sexual coercion among older sexual partners. Topic sensitivity and topic desirability, which are known to contribute to a tendency towards female underreporting and male over-reporting of sexual experiences could have disadvantaged the study (Ritcher et al 2015:305).

A survey was conducted to investigate recent reproductive coercion and unintended pregnancy of 3529 females aged 16-29 years, seeking care in rural and urban family planning clinics in Pennsylvania (Miller et al 2014:125). They found that recent RC is relatively prevalent among young women and is associated with unintended pregnancy. In their study, among the 5% that reported RC in the past three months, 12% reported past year unintended pregnancy. Compared to women exposed to neither RC nor IPV,

exposure to recent RC increased the likelihood of past year unintended pregnancy, both in the absence of IPV or in combination with a history of IPV.

Another study was conducted to investigate whether household family structure and parental vital status were associated with adolescent girls' risk of sexual coercion in Uganda (Pilgrim, Ahmed, Gray, Sekasanvu, Lutalo, Nalugoda, Serwadda & Wawer 2013:1289). The study revealed that being an adolescent and living with a single mother was protective against coercion. In addition, 4.1% of respondents living with single mothers reported coercion, compared with 7.8% of girls living with biological fathers and 20% of girls living with stepfathers. In this study, ever married girls whose mothers alone were deceased were more likely to report coercion than those with both parents alive. The study shed light on the role played by the family on the vulnerability of adolescents to sexual coercion.

In a themed paper on Adolescent's Health and Human Rights (Santhya & Jejeebhoy 2015:189), specifically adolescents in low and middle income countries (LMIC) findings indicated that many countries have yet to make significant progress in delaying marriage and childbearing and thereby reducing unintended pregnancies.

### 2.2.2 The impact of reproductive coercion (RC)

There were an estimated 580 million adolescent girls in the world by 2015 (United Nations, Department of Economic and Social Affairs, Population Division, 2013) as cited in Santhya and Jejeebhoy (2015:191). An overwhelming majority (88%) of them live in low-income and middle-income countries (LMIC). Many do not enjoy sexual and reproductive health (SRH) and most are denied the right to make safe and informed decisions that affect their health and well-being. Santhya and Jejeebhoy (2015:198) report experience of premarital sex among girls in sub-Sahara to be at 21% and most are coerced into engaging in sexual relationships. Husbands and partners perpetrate violence against girls and this starts early in relationships. This is a reflection of the egalitarian gender norms prevalent in most locations entrenched on patriarchy. WHO estimates that 29% of all ever-partnered girls aged 15-19 years experienced physical or sexual violence perpetrated by an intimate partner (WHO 2013) as cited in Santhya and Jejeebhoy (2015:191) and such violence is as high as 30% or more in such regions as sub-Saharan Africa and South Asia.

Unmarried, sexually experienced adolescents also report having been forced into having sex. Different methods of coercion have been mentioned in literature such as sex obtained through physical force, threats, deception, blackmail, or by drugging an unwilling victim (Santhya & Jejeebhoy 2015:192). Global review shows that girls and women who have experienced partner violence are more likely to have terminated pregnancy compared to those who have not experienced abuse (WHO 2013 cited in Santhya & Jejeebhoy 2015:192). This may further lead to other complications following TOP, like guilt, shame, anxiety, sleeplessness among others.

Coerced sex and early marriages are associated with a high rate of unintended pregnancies and TOP among adolescents. Estimates show that unintended pregnancy among women below age 20 ranged up to 27% in sub-Saharan Africa. Sadly, progress in reducing unintended pregnancy did not change in such regions as sub-Sahara Africa. In addition, an estimated 15% of nearly 22 million unsafe TOPs worldwide annually take place among girls aged 15-19, ranging from 11% in Asia to 22% in sub-Saharan Africa (Shah & Ahman 2012 as cited in Santhya and Jejeebhoy (2012:201). Moreover, 1% of all deaths among girls aged 15-19 globally in 2010 were caused by abortion-related complications (according to global burden of disease (GBD) estimates). South Asia and sub-Saharan Africa accounted for 48% and 38% respectively of these deaths.

### 2.2.3 Adolescent Sexual and Reproductive Health and Rights (ASRH&R)

Although adolescents require safe and supportive families, safe and supportive schools and positive and supportive peers, in many countries, the environment, including parent-child relationships and relationships between adolescents and their teachers or other potential adult mentors, falls short of meeting adolescents' needs and protecting their rights (Santhya & Jejeebhoy 2014:26).

In a review of the sexual and reproductive health and rights (SRHR) of adolescents, Santhya and Jejeebhoy (2014:20) stated that the situation of girls worldwide is compromised. For example, they reported declines in early marriages and early childbearing (6-7% to 6-10%) respectively in South and South East Asia. In sub-Saharan Africa there has been a 4% decline in multiple partner relations and a substantial 18% increase in condom use and in Eastern and Southern Europe there has

been a 15% increase in condom use. In Latin America and the Caribbean, pre-marital sex increased by 14% but condom use and multiple partner relations remained unchanged Santhya and Jejeebhoy (2014:20). As a result, unintended pregnancy increased substantially.

Much needs to be done regarding the empowerment, protection of their health and fulfilment of their human rights as well as increasing their age at marriage, reducing unintended pregnancy, early childbearing and subsequently the need for TOP, as well as safe and consensual sex within and outside marriage. These interventions will promote adolescents' knowledge and empower them to their full potential (Santhya & Jejeebhoy (2014:21).

To achieve progress in SRHR, there is a need for programmes at schools and at community level to not only focus on safer topics but on sexual relations among the unmarried, condom and contraceptive use, informed contraceptive choice, unintended pregnancy and TOP and sexual violence through the use of peer educators and Adolescent Friendly Health Clinics.

These topics need to be part of the teachers' training materials as well as the curriculum of schools. Appropriate linkages with supportive counselling, heath services and public education will ensure its acceptance.

According to the National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) framework of South Africa, the following trends and concerns were raised:

- Higher levels of sexual activity amongst male adolescents
- Sexually active adolescents below the age of 16
- Increasing trends of multiple, concurrent sexual relations
- Intergenerational sexual relations increase
- High level of substance use and abuse prior to sexual activity
- Low levels of consistent condom usage despite increased condom uptake
- High levels of HIV and AIDS among young people
- Increased STI treatment amongst female adolescents

- Vulnerability and sexual violence arising from poverty and disruption of the family.

Amongst these concerns, Sedgh et al (2015:8) allude that sexual activity and contraceptive non-use are immediate determinants of pregnancy incidence. The more distal drivers of teenage pregnancy rates are social, economic and cultural factors. National wealth, the pace of economic development and the magnitude of income inequality within countries within countries are associated with differences in teen birth rates between countries (Sedgh 2015:8).

There are still a number of gaps that exist in the promotion of young people's sexual and reproductive health and rights. SRHR is a basic human right for everyone and are fundamental to development conditions of any population. There is a need to invest in the SRH&R of adolescents through creation and strengthening of a responsive policy to meet the SRHS needs of adolescents. The National SRH&R framework is aligned to the South African Constitution and the Bill of Rights thereby adopting a human rights approach (National Adolescent SRH&R Framework 2015:3).

As the framework is multi-stakeholder and multi-sectoral in approach to addressing the gaps within the adolescent SRH&R, it is holistic in nature. As its key priorities, it focuses on increased coordination, collaboration, information and knowledge sharing for activities among stakeholders, innovative approaches to comprehensive adolescent SRH&R information, education and counselling to adolescent, strengthening ASRH&R service delivery and support on various health concerns, creating effective community support networks for adolescents and formulating evidence-based revisions of legislation, policies, strategies and guidelines (National Adolescent SRH&R Framework 2015:3).

## 2.3 GUILT

Guilt is the emotion associated with the awareness of wrongdoing by violating an important social, moral or ethical rule as well as following loss or a traumatic experience (Chaplin 1975 as cited by Nader 2016:1). Guilt is broadly recognised as an important emotion for self-regulation, yet some theorists view guilt mainly as either a

punishment indication or a pro-social motivator (Amodio, Devine & Harmon-Jones 2007:524).

Guilt is seen as a negative emotion where an individual focuses on an awareness of responsibility for an action or non-action that is against societal or personal standards (Day & Bobocel 2013:1). For moral and social functioning, an anticipation of feeling guilty in the future may help prevent individuals from participating in immoral acts that violate internalised standards. Day and Bobocel (2013:1) also note that people can experience anticipated guilt for future actions, vicarious guilt for the wrongdoing of close others and collective guilt for harms committed by one's in-group.

Freud explained guilt as operating to keep one's behaviour in line with moral standards while punishing id-inspired transgressions. Allport (1954 as cited in Amodio et al 2007:524), explained the purpose of guilt as causing a moral uneasiness that drives people to correct deviant behaviour. The importance of guilt in regulating social behaviour has caused the definition that guilt is a negative emotional experience that is evoked when one's behaviour falls short of personal or societal standards and that motivates reparatory behaviour (Lewis 1971 as cited in Amodio et al 2007:524).

Amodio et al (2007:524) describe guilt as something that helps one to act in accordance with the norms of society. It could also serve as a punishment for oneself, and if not dealt with, it may become chronic, resulting in ill-health and emotional turmoil. Research studies indicate that guilt is linked to a desire to confess, apologise, or atone for one's own wrongdoings (Tangney & Fisher 1995; Wicker, Pyne & Morgan 1983 as cited in Lickel, Schmader, Scarnier, Scarnier & Ames 2005:146).

In contrast, shame is more linked to reactions aimed at a desire to protect oneself from negative evaluation. Therefore, rather than making one to correct their action, feelings of shame evoke a desire to hide, disappear, or escape. In the case of TOP, a woman who expresses that she has a desire to apologise to her aborted baby is doing it from a motivation of guilt. On the other hand, when she avoids people she does it from a shame motive. Therefore, these two emotions differ in terms of the motivations they evoke and their associated considerations.

Shame and guilt also differ with on how an individual interprets a wrongdoing with respect to the self (Tangney 1996:742). Guilt for wrongdoing focuses on the specific, controllable behaviours that led to the wrongful occurrence, whereas feeling ashamed involves a more overall emphasis on what that event implies about the dispositional qualities one possesses. A woman who terminated pregnancy and feels guilty may indicate that what she did was disgusting and she is more likely to have a counterfactual thought, for example, for example,saying that she will ask for forgiveness from a higher. In contrast, a woman feeling ashamed would express that she is a bad mother, and wishes to disappear.

Individuals feel that they have more control over situations that they recall as guilt experiences. On the other hand, in comparison with guilt, shame involves a greater feeling of self-consciousness and a fear of being rejected by others (Smith, Webster, Parrott & Eyer 2002 as cited in Lickel et al 2005:147). Both shame and guilt accept personal responsibility for a negative event (Lickel et al 2005:147).

In vicarious guilt and shame, people feel guilty or ashamed for another's wrongdoing to the extent that they feel that person's behaviour was relevant to a social identity they shared in common with the wrongdoer and appraises the other person's behaviour as a negative reflection on themselves. In their study on vicarious shame and guilt, Lickel et al (2005:152) concluded that vicarious guilt predicts a desire to make amends for another's wrong and vicarious shame predicts a desire to distance oneself from the situation and the wrongdoer. In the situation of a woman who terminated pregnancy, the immediate family members may dissociate from her if they feel ashamed of her TOP.

From a phenomenological viewpoint, shame and guilt may be regarded as emotions, which have incorporated the gaze and the voice of the other respectively (Fuchs 2003:223). Shame and guilt are inseparably connected with the development of self-consciousness and the internalisation of interpersonal experiences, culminating in the dialogic structure of conscience. Both shame and guilt are prominently cited in theories of moral behaviour and psychopathology (Tangney 1996:741). Shame and guilt have each unique behavioural consequence in that guilt may produce more approach related behaviours intended to repair the situation that was caused by the guilt – causing event, whereas shame may cause more withdrawing behaviours designed to distance oneself from the situation. Some researchers (Tangney & Fisher 1995; Weiner 1986 as cited in

Fuchs 2003:146) show that under certain conditions, these emotions can be experienced for another's misdeeds, referred to as vicarious guilt or shame. Therefore, this section will discuss both guilt and shame in order to differentiate the two.

### 2.3.1 The medial frontal cortex (MFC) and social cognition

The neural mechanisms that underlie social understanding have recently been researched. The studies used approaches from neuroscience and social psychology as well as evidence from non-invasive neuroimaging methods such as MRI studies. These have shed light on the relationship of social cognition to the medial frontal cortex which is part of the frontal cortex (Amodio & Frith 2006:268).

According to Amodio and Frith (2006:268), social cognition consists of complex set of processes, which are carefully arranged to support skilled social functioning. It includes representations of internal somatic states, knowledge about self, perceptions of others and interpersonal motivations, among others.

Amodio et al (2007:525) conducted a study to test the hypothesis that guilt performs a two-stage function that involves an initial reduction in approach motivation … and an increase in approach motivation. They used electroencephalography (EEG) to monitor asymmetries in the subjects' frontal cortical activity during their experiences and responses associated with guilt. According to these researchers, a large body of literature has shown that frontal cortical asymmetry, as measured using electroencephalography (EEG), reliably corresponds to state approach-withdrawal orientation (Davidson 1992; Harmon-Jones 2003 as cited in Amodio et al (2007:525), such that relative left-sided asymmetry is related to approach and right-sided asymmetry is related to withdrawal (Amodio & Frith 2006:268).

### 2.3.2 Differences between guilt and shame

For many years, psychologists did not make a clear distinction between shame and guilt. According to Ausubel (1955) and Benedict (1946) as cited in Tangney (1996:741), guilt is viewed as a private experience involving the suffering of one's own conscience and shame was seen as an emotion arising from public exposure of some transgression or shortcoming. This definition was supported by Gehm and Scherer (1988:74 cited in

Tangney 1996:741), that shame is usually dependent on the public exposure of one's failing, whereas guilt remains a secret with the person, with no one else knowing of the breaking of social norms or of the responsibility for an immoral act.

An empirical study to test this definition was conducted by Tangney, Marschall, Rosenberg, Barlow and Wagner (1994) and Tangney, Miller, Flicker and Barlow (1996) as cited in Tangney (1996:742). The findings indicated that both shame and guilt were each most likely to be experienced in the company of others. Nevertheless, the shame experience reported by a substantial number of respondents (17.2% of children and 16.5% of adults) occurred when the respondent was alone and not in the presence of others. More importantly, solitary shame was about as prevalent as solitary guilt for either children or adults.

Another idea concerning the distinction between shame and guilt is that they are related to different types of transgressions or shortcomings. This is problematic in that content analyses of personal shame and guilt experiences provided by both children and adults in the study indicated that there were very few, if any, typical shame-inducing or guilt-inducing circumstances (Tangney 1996:742). However, there was evidence that non-moral failures were more likely to cause shame. The evidence indicated above shows that shame and guilt do not fundamentally differ in terms of the types of situations that provoke them but in the manner in which individuals interpret their transgressions or errors.

Today an influential elaboration that researchers draw from is that of Lewis (1971:30 as cited in Tangney 1996:742), which focused on key differences in the role of self in both shame and guilt. The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the thing done or not done is the focus of negative evaluation. Therefore, what matters is the individual's personal interpretation of the event-whether the individual places emphasis on a bad self or a bad behaviour. Amodio et al (2007:528) summarise that a critical distinction between guilt and shame is that feelings of guilt focus narrowly on one's transgression and therefore may be alleviated through reparation whereas shame implicates one's entire self-concept and is not easily alleviated through behavioural reparations. Furthermore, Amodio et al (2007:528) proposed the dynamic model of guilt (Figure 2.1) in support of the finding that guilt arising from a personal transgression was initially associated with a reduction in

approach motivation. This is indicated by online measures of frontal cortical asymmetry, as well as by the finding that when subjects were given the opportunity for reparation, their feelings of guilt predicted their interest in transgression-reducing behaviour, which in turn was accompanied by a strong approach-oriented shift in patterns of frontal cortical activity.

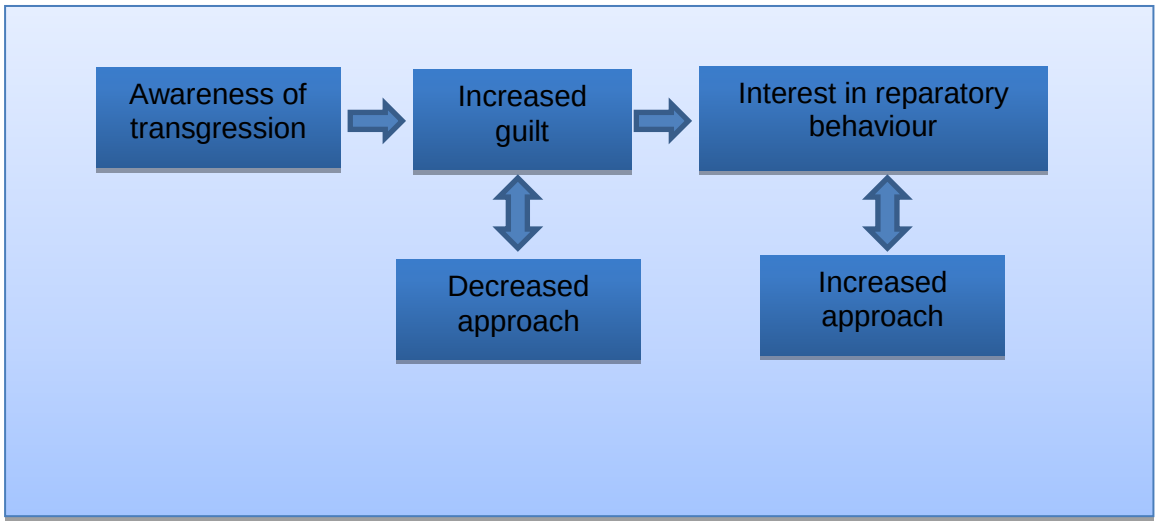



**Figure 2.1 A dynamic model of guilt**

(Amodio et al 2007:528)

As guilt is perceived to facilitate pro-social behaviour, this approach views guilt within a societal context in which serves to keep people's behaviour in line with the moral standards of those they have a relationship with for example, family and community as according to the social ecological model. According to this explanation, the moral transgression is defined by the internalised morals of the individual in the family, community as well as the society with which one finds herself and interacts. Therefore, a transgression will be relative to internalised moral standards of the community. The researcher suggests the inclusion of internalised moral standards of the guilty as part of this model.

In this study, the family and community's standards related to TOP determined awareness of transgression after TOP. Another challenge with TOP is that the death of the foetus is irreversible and therefore reparation will need to be done creatively for the woman to find closure.

### 2.3.3 The phenomenology of guilt and shame

According to Fuchs (2003:220), shame bears the origin of guilt. Shame becomes guilt when the social norms are internalised as one's own feelings of value and when self-condemnation anticipates public exposure. Fuchs (2003:220) refers to the assumption of the development of a personal centre, with the empowering capacity to regard oneself as the originator of one's actions to evaluate and feel responsible for them. Fuchs (2003:230) stresses that in contrast to shame, guilt is no more bound to the immediate presence of the other person – the impact of the other is more lasting. People who experience guilt feel that they are already executed and already abandoned for the wrong they committed, instead of feeling exposed or paralysed by the gaze of others in the present as it is in shame.

Conrad (1992:36) as cited in Fuchs (2003:230) describes the awareness of severe guilt, for example, of murder, as causing radical change in experienced space. In this study, as related to Conrad's (1992:36) observation, women who terminated pregnancy are inclined to feel that something in their lives has changed irreversibly and can never return to its former state. Conrad (1992:36) as cited on Fuchs (2003:230), stated, the guilty person feels depressed, calls to mind her acts again and again, even when away from her victim. The guilty person is tied to the past, he struggles to move on.

In elementary guilt, the person falls out of the common world and this experience feels like a void which has opened up between her and the others and which cannot be bridged again. As a result, every innocent gesture or word only increases the emotional pain of being expelled from others. With that, and like in shame, guilt causes corporealisation by the words said (Fuchs 2003:232).

The guilty person feels separated from others, cut off, with a feeling of dismay, sadness and depression, among others, and suffers a heavy weight, with feelings of regret (Day & Bobocel 2013:1). Guilt is a real emotion, and its heaviness may be sensed as a feeling of weight (Day & Bobocel, 2013:1). Evidence suggests that abstract metaphors like the expression of 'feeling heavy' may be grounded in real bodily experiences (Day & Bobocel 2013:1).

Although guilt and weight are seemingly unrelated, there is growing evidence from the field of embodied cognition that confirms that cognitions are grounded in sensations and actions of the body (Day & Bobocel 2013:1). For instance, recalling personal experiences of social exclusion increases reports of being left in the cold and reminders of immoral (that is, dirty) acts encourage motivations to cleanse.

Given the important role of guilt in personal and social functioning, Day and Bobocel (2013:1) sought to broaden the understanding of guilt by undertaking an experimental study to examine the effect of unethical acts on subjective body weight. The guiding hypothesis in this study was that immoral acts that can instil guilt would also lead to feelings of additional weight on the body compared to control conditions. One hundred and fifty three Canadian undergraduates were recruited for the study.

The findings of this study, as predicted in a significant one-way ANOVA (analysis of variance), indicated that subjective weight varied by condition, as seen in Figure 2. 1. On the contrary, it was revealed that compared to their average weight, participants in the unethical condition reported weighing significantly more ($M$=7.47, $SD$=1.63) than those in the ethical condition ($M$=6.57, $SD$=1.63), $p$=.007, and also more than control participants ($M$=6.79, $SD$=1.54), $p$=.03. There were no differences in subjective weight between the ethical and control conditions.

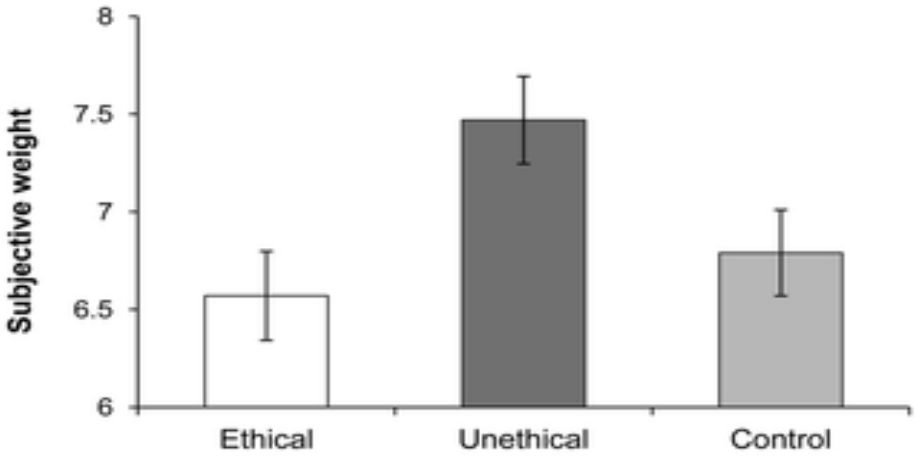



**Figure 2.3 Mean ratings of subjective weight following recall of ethical or unethical events, or no recall**

(Adapted from Day & Bobocel 2013:2)

Accordingly, when participants recalled an unethical memory, they reported higher than average subjective body weight compared to participants who recalled an ethical memory or did not recall a memory. These findings remained strong irrespective of participants' physical weight. As people sometimes mention feeling lighter or elevated after performing good deeds, this figurative language might lead one to predict that ethical acts could lighten one's perception of weight. Nevertheless, the authors (Day & Bobocel 2013:2) found that thinking of such actions did not lessen the typical sensation of body weight compared to a neutral condition. This study provided the evidence that violations of ethical standards may be embodied as sensations of body weight as it happens in feelings of guilt.

The guilty also experience the fear of desegregation, which is described by Bliz (1971) as cited in Fuchs (2003:232), as the fear of being abandoned, deserted or expelled from one's tribe, eventually losing the vital shelter of the group. Therefore, as in shame, the separation of the lived and the corporeal body forms a medium for the expression of guilt feelings. This would imply that with the feeling of guilt related to TOP, such women would need support of the significant others for better mental health.

This inhibition and weight bearing corresponds to the sticking of the guilty to the past. The culprit ponders and meditates over her motives and calls her actions to mind repeatedly. This causes her to be excluded from the living present and the imminent future. Unlike shame, guilt does not ease outside of the guilt-provoking situation. The situation accompanies the guilty individual all the time and attaches her to the victim even over a far distance. According to Fuchs (2003:231), to be guilty implies something unresolved or irreparable gets stuck in its unfinished state and like a foreign body resists melting as life progresses. Therefore, guilt ties the guilty to a past event, thereby interrupting the on-going behaviour and a reducing the approach tendencies in order to halt a transgression, survey the damage and learn from mistakes (Amodio et al 2007:525). Buber (1960:110 as cited in Fuchs 2003:231), noted that human beings appreciate their knowledge of time through interruptions of the flow of life, mainly through irreversible separations from others to whom our lives were related so far – be it through loss (as through death) or through guilt. Therefore, the standstill of time, the interruption of the flow of life, rejection, and expulsion are all equivalents of death (Lifton 1979 as cited in Fuchs 2003:231).

From a psychoanalytic point of view, Spitz (1967) and Bruner (1977) cited in Fuchs (2003:232) describe elementary guilt experience as how a child responds to parental refusals with an identification, that is, by internalising the interaction with a parent as an inner dialogue, speaking in contradiction to himself, thereby turning himself into his own object. Therefore, taking over the negation from others is the original form of self-reflexion as well as guilt. The external reproach and the external condemnation become the self-reproach and the self-condemnation of the guilty respectively. As Mead (1962:69 as cited in Fuchs 2003:232) puts it, it is the reflection of the words that the guilty hears herself speaking, because he took in the attitudes of the other person into his own conduct. Therefore, the guilty are, especially through the use of vocal signals, forever awakening in themselves those responses which they call out in other persons, thereby taking in the attitude of other person into their own conduct. Against this background, the guilty women who underwent TOP gradually incorporate the judgement of others and they oppose their own endeavours by judging them negatively, recalling at the same time the negative feelings that go with the reproach (Mead 1962:69 as cited in Fuchs 2003:232).

Guilt therefore represents the incorporated negative voices from family members, from religious bodies, from friends, amongst others, just as shame represents internalised negative gazes from others. Both shame and guilt are inseparably connected with the development of self-consciousness and the internalisation of interpersonal experiences, which result in the dialogic structure of conscience. Conscience attests to guilt. It is as if the guilty has a “prosecutor” inside of herself, who, as an incorruptible, autonomous foreign power confronts the guilty. A personal conscience is fully developed during adolescence, and this is experienced as a personal responsibility that has taken on an integrated central interpersonal values.

To cope with tormenting feelings of guilt and shame, Fuchs (2003:233) suggests that the guilty adopts a meta-perspective on one’s relation to others. This enables the guilty to assert herself in the face of devaluating gazes or reproaches by transcending the actual painful situation for example, guilt feelings as after TOP, by anticipation of spiritual reconciling with the dead foetus or through reparation.

In this way, meta-perspective helps one to cope with tormenting feelings of shame and guilt (Fuchs 2003:233) since others' gaze or voices are relaxed or removed, and the body's own space is extended again.

Integrated in one's personality, shame and guilt regulate interpersonal relations. As a result, shame protects from being wounded through self-exposure and self-revelation before others whereas guilt and conscience indicate a hurting of others that could lead to a break in our relations with them. Adopting a meta-perspective in situations of shame or guilt helps to cope with the inherent self-devaluation and corporealisation.

Integrating these views, Amodio et al (2007:524), in their study on A Dynamic Model of Guilt, note that guilt functions dynamically to first provide a negative reinforcement signal associated with reduced approach motivation, which transforms into approach-motivated behaviour when an opportunity for reparation presents itself.

The authors tested this hypothesis in the situation of racial prejudice where white subjects viewed a multiracial series of faces while cortical activity was recorded using electro-encephalography. Following fake feedback indicating anti-black responses, subjects reported elevated guilt, which was associated with changes in frontal cortical asymmetry indicating reduced approach motivation. When subjects were presented with an opportunity to engage in prejudice-reducing behaviour, guilt predicted greater interest in prejudice reduction, which in turn was associated with an approach-related shift in frontal asymmetry. The results supported a dynamic model in which guilt was associated with adaptive changes in motivation and behaviour.

As Amodio and Frith (2006:268) note, survival for humans depends on effective social functioning. Social skills involving the handling of shame and guilt facilitate access to sustenance, emotional and mental protection. Socially adept individuals tend to be healthier and to live longer. However, social interaction in humans is remarkably complex as it involves representations of internal somatic states, knowledge about self, perception of others, and the interpersonal motivations. These must be carefully coordinated to support capable social functioning.

There is a need for health professionals to understand guilt and shame as perceived in order to intervene effectively when counselling women who are laden with guilt after TOP.

### 2.3.4 The phenomenology of shame

According to Fuchs (2003:223), guilt and shame belong to the self-related and self-evaluating emotions. Shame and guilt (Fuchs 2003:220) both cause a feeling of rejection, of being separated from others and thrown back on one's self. According to Fuchs (2003:223), the lived body (bodiliness), which mediates one's relation to the world, is changed into the objective, corporeal body or 'body-for-others'' (corporeality). The phenomenological structure of shame means that the lived-body has taken up and internalised its being seen, and its exposure before the eyes of the others becomes a part of its feelings. Fuchs (2003:228) concludes that shame is the incorporated gaze of the other such that what one is, is what one performs or the role one plays because she is separated from his natural and sensual existence.

Shame and guilt tend to have differential relations with a host of outcomes. Shame typically arises in situations of disclosure, exposure or uncovering of a hidden action, being caught at doing something immoral or ridiculous and therefore left naked and unprotected to the eyes of the public, with feelings of self-consciousness, shame and being rejected (Fuchs 2003:230). Shameful nakedness results from the interruption of pure and primitive self-expression by the gaze and the disapproval of the other. Through this exposure, the self becomes needy or vulnerable in some way owing to her knowledge of morality (through religiosity, norms and values of culture). In the case of exposure of one's TOP to her immediate acquaintances, the woman may be judged or stigmatised for her failure to live to the expectations of others or the norms of decency, leading to an experience of painful feelings of shame and rejection. Shame-prone persons are predisposed to blame their entire self for a behavioural transgression, whereas a guilt prone person is more likely to identify their specific behaviour as problematic.

According to VanDerhei, Rojahn, Stuewig and McKnight (2014:318), shame proneness is regularly positively associated with a diversity of internalising symptoms. These include depression (Stuewig & McCloskey 2005), social and generalised anxiety

(Fergus, Valentiner, McGrath & Jencius, 2010), eating disorders (Goss & Allan 2009), as well as externalising and risky disorders such as anger (Tangney et al 1992 as cited in VanDerhei et al (2014:318), substance use (Dearing, Stuewig & Tangney 2005) as cited in VanDerhei et al (2014:318), criminal offending and suicidality (VanDerhei et al 2014:318). Shame is considered the more painful emotion because one's core self (not only one's behaviour) is at stake (Tangney et al 2007:349), the entire self is blamed for the wrong. Over and above, according to VanDerhei et al (2014:319), shame is associated with defensiveness, separation and distancing from others.

In contrast, guilt proneness is related to good social adjustment, "other-oriented" empathy which in turn promotes prosocial behaviour and close interpersonal relationships (VanDerhei et al 2014:319). Feeling of guilt is also associated with wanting to make and fixing what is wrong and may therefore serve as a protective factor from engaging in suicide ideation.

In their study on suicidality, using data from two different samples of undergraduate students, Hastings, Northman and Tangney (2000), as cited in VanDerhei et al (2014:319), resolved that shame proneness was positively related to suicide, non-suicidal self-injury while guilt proneness, when controlling for shame, was generally unrelated or slightly negatively related to suicidal self-injury. The findings of this study were made in light of the limitation that the measures of suicidal self-injury were single-item questions.

VanDerhei et al (2014:325) asserts that high shame proneness is a consistent risk factor across levels of internalising tendencies. However, the protective effect of high guilt-proneness is weakened when a person also suffers from high levels of internalising tendencies meaning the motivational and reparative function of high guilt-proneness, although still protective, is less influential for a person who is more anxious or has depressive symptoms. Conversely, guilt-prone people still feel bad and their feelings motivate compensatory action as a way of correcting wrong behaviour without implicating their entire self. Their "other oriented" corrective actions make it less likely that those high in guilt-proneness would turn inwards and inflict harm upon themselves. Nevertheless, a person with high levels of guilt-proneness, who is also relatively more depressed and/or anxious may not be as compelled to cope with his or her symptoms in

much more productive and adaptive ways as compared to a person with less depressive or anxious symptoms.

Seeing that shame and guilt are interrelated, it is important to take into consideration the level of shame when intervening on women who are laden with guilt after TOP. In his study on the phenomenology of shame, guilt and the body in body Dysmorphic Disorder and depression, Fuchs (2003:240) alludes to shame and guilt as reflexive emotions being closely connected to the development of self-consciousness and intersubjectivity. Shame and guilt assume the ability to see oneself with the eyes of the other and to speak to oneself as the others do. Shame and guilt incorporate devaluating gazes or voices, which in turn corporealize the lived body. However, their regulating role in the interpersonal sphere is also dependent on the ability to adopt a meta-perspective on the relation of self and other, because this higher viewpoint allows the ashamed or guilty person to make relative his/her present feelings in view of a possible reconciliation and compensation. Only if this higher viewpoint fails, shame and guilt may gain a persistent, unbalanced power.

The lived body then loses its uninhibited spontaneity in performance and participation in the world and this may lead to somatic symptoms. At the same time, the gaze or the voices of an imagined other trap the woman, surrounded by a world of disapproval and accusation. Totally identified with her present experience, she loses the capacity to change perspective and to transcend the situation towards an intersubjective, higher order view. Fuch (2003:223) alludes that the divergence of “bodiliness” and “corporeality” explains the phenomenological understanding of several mental disorders related to shame and guilt. Extreme guilt and shame threatens the capability of adopting a meta-perspective that depends on an interpersonal space, which allows for freedom of self-distancing. Fuch (2003:241) concludes that shame and guilt play an important role in certain pathological conditions even though these may not be understood as their mere extensions.

## 2.4 SELF-FORGIVENESS

### 2.4.1 Definition of self-forgiveness

The current literature on self-forgiveness is partly weighed down by a lack of a single, widely accepted and shared definition. Some researchers define self-forgiveness in terms of willingness to be kind to the self after abandoning self-resentment (Enright 1996 as cited in Terzino 2010:2); others define it as a motivation to avoid self-retaliation and increase benevolence towards the self (Hall & Fincham 2005:622). There is an increase of definitions, but as Worthington and Scherer (2004:400) observe, these definitions are in many ways complementary rather than competing.

According to Hall and Fincham (2008:175), self-forgiveness is an emotion- focused coping strategy that involves reducing negative and increasing positive emotions, motivations and behaviours regarding oneself. Worthington (2004:385) stresses that it reduces the stressful reaction of unforgiveness after being transgressed against. It is actually one of the many ways people use to reduce unforgiveness. It is a connection of positive emotions, (including empathy, sympathy, compassion, or love) against the negative emotions of unforgiveness (Worthington 2004:385) which create physiological, cognitive, motivational, behavioural, and emotional stress reactions.

According to Hall and Fincham (2008:174), a limitation with these definitions is that they fail to integrate the interpersonal as well as the intrapersonal forgiveness processes. To overcome this limitation, self-forgiveness has been defined as a set of motivational changes whereby one becomes decreasingly motivated to avoid stimuli associated with the offense (for example, the victim), decreasingly motivated to retaliate against the self (for example, punish the self, engage in self-destructive behaviours), and increasingly motivated to act benevolently toward the self.

An interpersonal transgression (for example, terminating the life of a foetus), may be a behaviour, thought or emotion that goes against personal ideal. Transgressing against the self may be difficult to forgive as the behaviours are compounded by thoughts and desires for example, when forgiving oneself for terminating a pregnancy, it is not only the guilt about the action that will cause distress but also the shame that " I am a

failure" that must be integrated into the view of self. Efforts encouraged by feelings of guilt to make amends do not guarantee self-forgiveness (Scherer 2010:7).

Guilt may be trait or state and the ease with which it may be overcome can vary intensely. With state guilt, making amends easily promotes self-forgiveness, but will not guarantee it. When guilt endures, the individuals may end up condemning themselves. For self-forgiveness to occur, the offender must take responsibility for his or her action and experience remorse (Hall & Fincham 2005:623). Self-forgiveness is a process that unfolds over time, requires an objective wrong for which the offender is not entitled to forgiveness but grants herself the forgiveness nonetheless. Neither self-forgiveness nor interpersonal forgiveness imply that offences should be condoned, excused or forgotten. Despite the similarities, there are differences. Table 2.1 outlines the differences.

**Table 2.1 Differences between self-forgiveness and other-forgiveness**

| **Area of difference** | **Self-forgiveness** | **Other forgiveness** |
|---|---|---|
| 1 Target of avoidance | Avoid the victim and/or thoughts, feelings, situations associated with the transgression | The victim evading the transgressor |
| 2 Conditional nature | May be contingent on a variety of factors for example, continued reparations to the victim of one's offense | Unconditional |
| 3 Implications for reconciliation | Reconciliation with the self | Need not reconcile with the offender |

(Hall & Fincham 2008:176)

Scherer (2010:5) proposes two types of forgiveness, namely, decisional forgiveness (which is a behavioural intention statement that one will seek to behave toward the transgressor like one did prior to a transgression. One decides to release the transgressor even though can still be emotionally upset). The second type is emotional forgiveness. Worthington (2000) as cited in Worthington (2004:386) theorised that people who are offended or hurt experience an injustice gap, which is described as the difference between the way one would prefer a transgression to be fully resolved and the way they perceive the situation currently.

The injustice gap widens as subsequent events aggravate the person or narrows as subsequent events mitigate the injustice. Magnitude of the injustice gap is hypothesised to be inversely proportional to ease of forgiving and directly proportional to unforgiveness. In self-condemnation, a state of negative self-evaluation accompanied by negative self-focused emotions, the person may have done something he/she believes is wrong, shameful or immoral, for example, TOP. Furthermore, the person may believe that he/she does not measure up against some internal standard governing her character. Self-focused emotions include the complex that make up unforgiveness, that is, resentment, bitterness, hostility, hatred, anger or fear, directed against the self for moral or character failure. Guilt and shame may play a role because one is experiencing one's own moral failure or character deficiency. In unforgiveness towards an aggressor, the person can narrow the injustice gap through several coping strategies for example, acceptance, surrendering judgement to God, seeking justice amongst others.

Self-condemnation can be dealt with in different ways and one important way is self-forgiveness. Some alternative ways to handle self-condemnation may include seeking Divine forgiveness, and engaging in restitution or penance or atonement (Scherer 2010:6). On the contrary, self-forgiveness entails repairing damage to one's self-concept, to resolve emotional distress, which includes anger, guilt, shame, regret, and disappointment that result from perceived incongruity between one's values and behaviour (Enright 1996:115).

### 2.4.2 Self-forgiveness model

Hall and Fincham (2005:630) created a model of self-forgiveness based on the concepts of self-forgiveness and forgiveness of others. The authors' model of self-forgiveness depicts emotional determinants (i.e. guilt and shame), social cognitive determinants that is, attributions) and offence-related determinants (i.e. conciliatory behaviour, perceived forgiveness from victim or higher power, severity of offence) in the path to forgiveness of self.

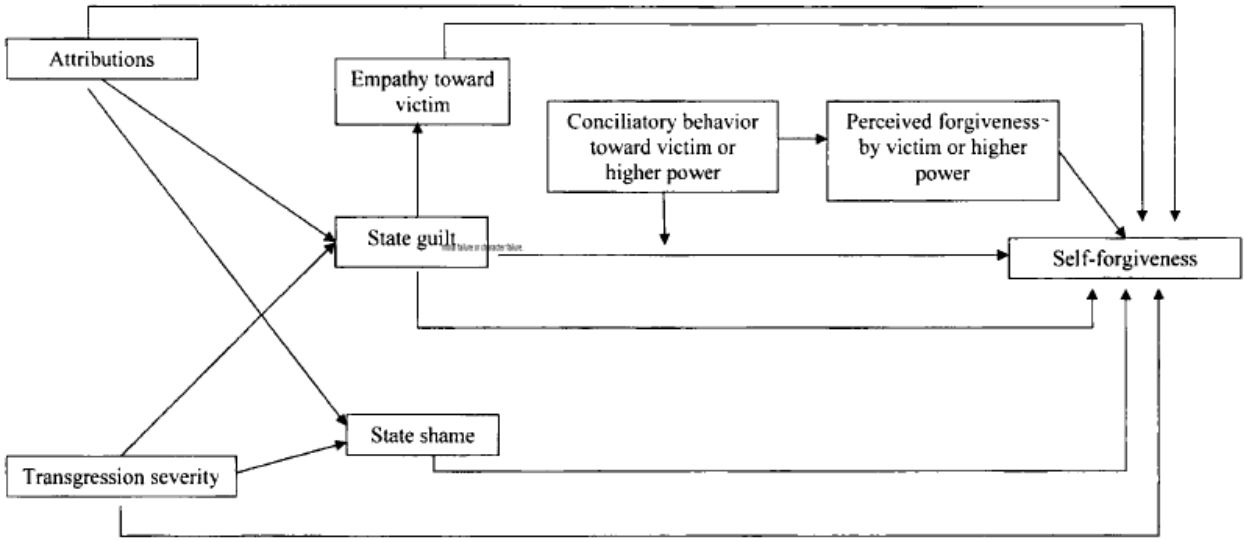



**Figure 2.4 Model of self-forgiveness**

(Adapted from Hall & Fincham 2005:630)

The model depicts self-forgiveness of specific interpersonal transgressions. In relation to this study, it depicts self-forgiveness of having terminated pregnancy. The transgressor is the mother, the offended is the foetus and a higher being and the transgression severity will depend on how the woman interprets TOP. The influence of religion will determine perceived forgiveness of a higher power.

According to Terzino (2010:10), the following are additional correlates that have been added to Hall and Fincham Model:

- Rumination: there is a negative correlation between state rumination and forgiveness.
- Time since the offence: Time since the offence is positively correlated with interpersonal forgiveness. For intrapersonal offences, self-forgiveness will occur quickly than for interpersonal offences.
- Action versus inaction: Remorse and regret produce anger which becomes a barrier to self-forgiveness
- Depression and anxiety: Unforgiveness is related to increase in guilt, shame and regret. Individuals who have difficulty forgiving the self are likely to experience depression and anxiety.
- Self-compassion: Self-compassion is positively associated with self-forgiveness.

- Need to belong: Committing an interpersonal transgression for these people would make it hard for them to forgive self.
- Neuroticism: Neurotic people tend to experience unpleasant emotions more easily than individuals who are not neurotic, such that neuroticism is negatively associated with self-forgiveness.
- Trait-forgiveness: It is an individual's general disposition to forgive. Individuals who are high in trait forgiveness are more likely to forgive the self than those low in trait forgiveness.
- Narcissism: Narcissistic individuals would be less willing to forgive interpersonal offences but easily forgive the self.
- Self-esteem: There is a negative association between forgiveness of others and self-esteem but a positive association with self-forgiveness.
- Commitment, closeness and relationship satisfaction: Forgiveness is likely to occur in relationships that are committed, close and satisfying but will make it more difficult to self-forgive for an interpersonal offence.

The above correlates of self-forgiveness indicate that certain aspects of an individual's personality should be taken into when studying self-forgiveness. It is relevant information for self-forgiveness interventions because particular personality traits may hinder the self-forgiveness process, and subsequently the lack of self-forgiveness may result in poor mental health.

### 2.4.3 Benefits of self-forgiveness

Self-forgiveness is theorised to be more closely related to psychological and physical health than other-forgiveness. In their meta-analytic review study, Davis, Griffin, Hook, DeBlaere, Man Yee Ho, Bell, Tongeren and Worthington Jr (2015:330) sought to estimate the correlation of self-forgiveness primarily with physical health and psychological well-being. These included mental health outcomes (that is, depression, anxiety, traumatic symptoms, life satisfaction/meaning, general mental health, alcohol use and suicide symptoms), emotions, (like state anger, state guilt, state shame) and with relationship outcomes, (that is relationship quality, perceived social support, forgiveness of other, feeling forgiven by others).

The limitation of this review was that studies almost exclusively relied on self-report measures of physical health symptoms, unlike studies of other-forgiveness that employ biomarkers of health (Da Silva, VanOyen Witvliet & Riek 2017:362). Despite these limitations, it was concluded that self-forgiveness was associated with physical health and psychological well-being, as well as other mental health correlates. Moreover, the study found that self-forgiveness was moderately to strongly correlated with depression. Taken together, the findings provide initial support for the claim of Worthington et al (2007) that forgiveness of oneself may be more related to mental health outcomes in comparison to forgiveness of others. Finally, self-forgiveness was generally associated with positive relationship outcomes where correlations ranged from weak to moderate. Therefore, based on studies in the present review, according to Davis et al (2015:332), people scoring high in self-forgiveness generally perceive themselves as surrounded by a supportive social network and generally perceive being forgiven by others, meaning that self-forgiveness is advantageous to relationships. Findings also revealed that the relationship between self-forgiveness and health decreased as the mean age of the sample increased, also that the relationship between self-forgiveness and physical/mental health weakened as the percentage of males in the sample increased. More research is needed to account for this impact.

Self-forgiveness can help individuals resolve negative judgements and emotions that discourage self-care, discourage adaptive coping, impair interpersonal relationships, and intensify distress. It can alleviate negative emotions, for example, anger, guilt, shame, regret, or disappointment associated with physical or mental health problems (Davis et al 2015:330), partially explaining the difficulties that clients have connecting with others, accepting themselves and achieving personal growth (Davis et al 2015: 330).

According to Worthington and Scherer (2004:394), forgiveness reduces hostility, anger, prevents the elevation of pro-inflammatory cytokines. Therefore, it prevents the dysregulation of the immune system at cellular level. Forgiveness affects health by boosting the immune system at neuro-endocrine level, by reducing secretion of cortisol, which when hyper-secreted, can have adverse effects on the cardiovascular system, the immune system as well as the cognitive and brain functioning. Moreover, people high in salivary cortisol are found to be high in trait unforgiveness and those who are in troubled relationships are found to have cortisol reactivity. Unforgiveness as a stress

emotion can affect the immune system through the suppression of the release of antibodies. Another way through which forgiveness regulates vengeance is through stimulating serotonin release, which inhibits testosterone production in the hypothalamus (McCullough & Hoyt, 2003) as cited in Worthington and Scherer (2004:397). At the level of the central nervous system (CNS), three processes might be affected:

Motivational systems, of which Behavioural Inhibition System (BIS) is one, increases arousal and interrupts ongoing behaviour, preparing the organism for focusing attention on aversive or novel stimuli. BIS is primarily associated with anxiety. Emotions can stimulate the Behavioural Activation System (BAS), which is associated with both the positive and the negative emotions. Both BIS and BAS arouse and motivate the organism to engage with the environment. The BAS has been shown to be involved with extreme happiness, aggression and anger (Harmon-Jones & Allen 1998 as cited in Worthington & Scherer 2004:396). Harmon-Jones, Abramson, Sigelman, Bohlig, Hogan and Harmon Jones (2002) as cited in Worthington and Scherer (2004:397), have examined 67 people's responses to an anger-evoking event. Using EEGs, they found a relative increase in the left frontal cortex activity. Individuals who showed tendencies to actively cope with their anger showed more BAS activation, and individuals who showed more tendencies toward depression and inhibited coping showed less BAS activation. This study suggests that unforgiveness – which involves anger, and forgiveness, which is theorised to involve active emotion-focused coping and use of positive emotions to regulate the negative emotions, might be associated with people who have an active BAS. People whose BIS is more active might be more likely unforgiving, and be anxious about being hurt in future interpersonal interactions (Worthington 1998 as cited in Worthington & Scherer 2004:396).

On the contrary, the hypothalamus is rich in receptor sites for both testosterone and serotonin hormones and the hypothalamus has been implicated in motivational processes. Forgiveness, as an emotion-focused coping strategy, might inhibit testosterone by stimulating serotonin release. This potential connection would support McCullough's (2001 as cited in Worthington & Scherer 2004:396) suggestion that the regulation of vengeance by forgiving is a fundamentally motivational process.

Forgiving people might be assumed to have high vagal nerve tonality. Unforgiving people are theorised to react quickly to an interpersonal threat by rapidly decreasing vagal tonality. Vagal nerve tonality has been found to be related to cardiovascular diseases, emotional expression and emotion regulation (Worthington & Scherer 2004:396).

Other health benefits of forgiveness are that forgiving people might have more emotionally supportive networks. They might have less stressful marriages, as they can resolve conflict more thoroughly, might have personality traits that are related to health and might be related to relationship skills (Worthington & Scherer 2004:399). In this study, women who might be laden with guilt may display maladaptive coping strategies to having terminated their pregnancies during adolescence and Scherer (2010:3) suggests that one way of dealing with these stressors may be to promote self-forgiveness within the individual.

## 2.5 CONCLUSION

In this chapter, literature related to reproductive coercion, guilt and shame as related to TOP, reproductive coercion, as well as self-forgiveness was studied in order to establish the theoretical roots of this study and the relationships between these themes. Reproductive coercion has an impact on unwanted or mistimed pregnancy and coerced TOP. IPV and RC are highly prevalent among adolescents and account for high prevalence of TOP amongst adolescents. IPV and RC are related to stress among adolescents and this could lead to negative psychological impact related to TOP, for example, guilt and shame. There is need for self-forgiveness when intervening to counsel women after TOP. The next chapter discusses the methodology for collecting and analysing data for this study.

# CHAPTER 3

# PHASE 2: METHODOLOGY

## 3.1 INTRODUCTION

This chapter provides an overview of the research methodology that the researcher used in this study. The research design, research methodology, data collection, and data analysis are discussed in detail. Measures to ensure trustworthiness as well as ethical considerations, including methodological issues encountered were included in this chapter. The researcher explored and described the lived experiences of women aged between 20–35 years, who terminated pregnancy during adolescence, using a qualitative approach. Interpretive phenomenology proposed by Heidegger (1962) guided this study.

## 3.2 METHODOLOGY

According to Polit and Beck (2014:733), methodology entails all the procedures and strategies used and followed from data gathering to data analysis (Polit & Beck 2014:733). This section covered the research strategy, design, context, the population, sampling, data gathering, as well as data analysis.

### 3.2.1 Research strategy

A research strategy is a process that has guided the researcher to move from their own perspectives through research design to data collection and analysis. According to Botma et al (2010:189), a strategy links the researcher to specific methods that are relevant to the study for data collection and data analysis. The purpose of the strategy is to assist the researcher to identify relevant data collection and data analysis methods.

The strategy used in this study was based on the qualitative approach guided by the phenomenological philosophy. Phenomenology is a philosophy that had its beginnings in the early years of the 20th century. As a philosophy, it seeks to understand anything that can be experienced through the consciousness one has of whatever is given, from

the perspective of the conscious person undergoing the experience. Guided by a phenomenological approach, women's experiences about TOP were precisely analysed as experienced by the women themselves (Husserl 1913 as cited in Giorgi 2009:4).

In this study, a phenomenological approach maintains that each woman who terminated pregnancy is unique and that as human beings these women are forever involved in making sense of their TOP experiences by interpreting, creating, giving meaning, defining, rationalising, and justifying these experiences (De Vos et al 2012:8).

Phenomenology has been defined as the study of lived experience (Beck 2013:149). Munhall (2012 as cited in Beck 2013:149) emphasises that language is critical to expressing these lived experiences so that the voices of the participants may be heard unfiltered through the researchers' lens of his/her world. The situated context of each participant, that is, the life-worlds of spatiality, temporality, embodiment, and relationality are important to understanding the situated meaning of their experiences.

In this study, the researcher described and interpreted the lived experiences of women about the phenomenon of guilt related to TOP, as described by participants. The description culminated in the essence of the experiences for these women who have all experienced TOP (Creswell 2014:14). According to Grove et al (2013:57), a qualitative approach always flows from a philosophical standing that guides the questions asked and the methods selected for the study as well as the way the researcher conducts the study through providing ideas or beliefs (Botma et al 2010:40). In addition, phenomenological researchers in nursing commonly base their study designs on either Husserl's (1962) or Heidegger's (1962) philosophy whose points of view of the person and the world in which that person exists, differ. Husserl's (1962) philosophy supports descriptive phenomenological approach whose purpose is to describe experiences as they are lived, whereas Heidegger's (1962) philosophy affirms that the researcher interprets the data, creating a strong, insightful text that brings to the mind the meaning of the phenomenon (Flood 2010:8; Giorgi 2012:6).

#### *3.2.1.1 Historical overview of phenomenology*

Converse (2012:28) asserts that researchers should know the history and the philosophical underpinnings of phenomenology in order to produce philosophically

compatible and phenomenological research findings. However, phenomenology is not based on theoretical concepts but rather on philosophical propositions. Phenomenology studies events and trends from a human perspective with the intention of developing a deeper understanding of everyday experiences (Converse 2012:28; Munhall 2012:113).

According to Holloway and Wheeler (2010:213), phenomenology has three major streams: the descriptive phenomenology of Edmund Husserl (1859-1938), the hermeneutic phenomenology of Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002), and the existentialist phenomenology of Merleau-Ponty (1908-1961), and Jean-Paul Sartre (1905-1980). These streams overlap and have differing features. For the purposes of this study, only the historical development of the streams of Edmund Husserl (1960), Martin Heidegger (1960) and Hans-Georg Gadamer (1976) will be briefly discussed as they impacted on this study.

- **Edmund Husserl's phenomenology**

A German philosopher and founder of phenomenology, Husserl (1859-1938) studied mathematics and philosophy. He named his philosophy phenomenology, which means a systematic attempt to uncover and describe the structures of lived experiences and aims at gaining a deeper understanding of the phenomenon. Moreover, he developed descriptive phenomenology, which emphasises knowledge of essences, themes, essential structures of an experience, which can be considered universal. In order to see things "as they are" intuitively, phenomenology requires the researcher to set aside any assumptions, through bracketing, to prevent the researcher's biases. Husserl's phenomenology aims at exploring the conscious lived experiences of phenomenon as it is perceived in daily encounters (Pascal 2010:3).

- **Martin Heidegger's interpretive phenomenology**

Martin Heidegger, a student of Husserl, investigated the meaning of experience, the meaning of being human within the different situated contexts of being. He believed that human beings are capable of finding significance and meaning (hermeneutics) in their own life experiences. He asserted that phenomenology addresses the situatedness of an individual's human way of being- in- the- world, that is *dasein*, and

has the ability to question its (human) own being. Heidegger challenged Husserl's idea of reduction by theorising that human beings are embedded in their life worlds, linked to social, cultural and political contexts that he called situated contexts (Beck 2013:151).

For this study, interpretive phenomenology as a philosophy proposes that researchers have a means of inquiry that not only leads to understanding women who terminated pregnancy but also to understand the meaning of the experience of TOP and related guilt for those women (Beck 2013:148). Interpretive phenomenology, alternatively known as hermeneutics (Beck 2013:149), focuses more on the importance of meaning.

Adopting this philosophy helps reduce misunderstandings, conflicts, as well as complications in communication and in nursing practice. Researchers and health practitioners, once they have internalised interpretive phenomenology as a philosophy, will be able to embrace the complexities, ambiguities, uncertainties and the messiness of life situations between and among people (Beck 2013:149). In the case of women who terminated pregnancy during adolescence, researchers will approach them without being judgemental.

In the present study, preconceptions had to be made known and held in abeyance in tandem with the hermeneutic phenomenology (Lopez & Wills 2004 as cited in Beck 2013:151). Following interpretive phenomenology, the importance of having participants interpret the transcribed text of their narratives or texts was maintained in order to show what they did mean in their personal description of their experience (Munhall 2012:151).

Hermeneutic phenomenology as a philosophy is designed to uncover obscured meanings in the phenomena (Strebert & Carpenter 2011:84), to understand knowledge gained through interpretation or, as according to Manen (1990:26), to describe one's interpretation of the text of life. Hence, hermeneutics encompass all situations in which humans encounter meanings, which are not immediately understandable and therefore require interpretation. Through interpretive phenomenology, personal and hidden meaning of experiences were exposed. Therefore, it was important in this study that the researcher understood the meaning and interpretations of experiences of women about TOP, guilt, reproductive coercion, and self-forgiveness.

A critical assumption of Heidegger's phenomenology is its emphasis on language, which imbues and informs experience. According to Munhall (2012:35), language does not exist apart from thought or perception, for language reveals and conceals who we are to ourselves and to the world.

In Heideggerian phenomenology, language and culture are important for the handing down of interpretation and self-understanding and this is referred to as background (Allen, Benner & Diekelmann, 1986 as cited in Beck, 2013:150). Background provides conditions for human actions and perceptions because it is an individual's history to her present moment and a view of what is possible. Another tenet of Heideggerian philosophy is that meaning is found in the transaction between an individual and a situation such that an individual both constitutes and is co-constituted by the situation.

- **Hans-Georg Gadamer's (1900-2002) hermeneutic phenomenology**

The hermeneutic phenomenology inspired by Gadamer (1990) influenced this study as well. According to Polit and Beck (2014:271), hermeneutics is the art and philosophy of interpreting meaning. Hans-Georg Gadamer (1900-2002) was a student of Heidegger who developed hermeneutic phenomenology different from that of Heidegger. Hans-Georg Gadamer assert that understanding phenomena could be done through dialogue which will make researchers more receptive to or open towards participants' opinions or ideas. Likewise, a significant aspect that connects this study to Gadamer's hermeneutic phenomenology is that through dialogue, language was vital to understanding each other, that is, the interviewer and the participants.

In this study, language was used during individual face-to-face interviews because exploring the meaning and interpretations of the experiences of women regarding guilt related to TOP necessitated language use. Language enabled the researcher to achieve a deep understanding of the phenomenon of guilt related to TOP.

A philosophical perspective that guided this study was the interpretive phenomenology, also referred to as the hermeneutic phenomenology (Polit & Beck 2014:271) of Heidegger, as it focused on the researcher's interpretation of meanings related to experiences of TOP as were perceived, lived and described by participants prior to and independent of the scientific knowledge (Beck 2013:134).

#### *3.2.1.2 Interpretive phenomenology*

Edmund Husserl (1913-1954) was the first to apply phenomenology as a philosophical approach to social sciences by stating that we can only know what we experience by paying attention to perceptions and meanings that awaken our consciousness (Patton 2015:116). According to Botma et al (2010:40), interpretivism relates to how people interpret their own world through thinking about their experiences. The goal of interpretive phenomenological approach was to enter each participant's world and to discover their wisdom and understanding of guilt as related to TOP during adolescence.

The researcher adopted Munhall's approach (Beck 2013:149) to interpretive phenomenology of exploring the meaning of experiences with the participants themselves, rather than extracting the meaning from narratives. Where the researcher was compelled to extract meaning from the narratives, she returned to the individual participants to ensure that the participants interpreted their own words, showing what they did mean in their personal description of the experience. The question of meaning was incorporated in the dialogue (interview) with participants. The researcher had to repeatedly verify with each participant what she meant, by asking "I am not sure what you mean by that".

Heidegger's view is that the researcher interprets the data, thereby creating a strong insightful text that brings to mind the phenomenon described and giving insight into the meaning of the phenomenon (Giorgi 2009:77).

What the various phenomenological approaches share in common is a focus on exploring how humans make sense of experience and transform experience into consciousness, both individually and as a shared meaning. This requires the researcher to thoroughly, carefully and methodologically capture and describe how people experience some phenomenon, including, among others, how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it (Patton 2015:115).

To obtain this information the researcher needed to undertake in-depth interviews or dialogues with women who directly experienced the phenomenon of TOP during

adolescence. The individual women interpreted their own experiences and through dialogue, searched and found the meaning of their experiences. Phenomenology buttresses that experiences should be holistically analysed and described as they are (Grove et al 2013:60), with the researcher remaining open to the participant's worldview, setting aside personal viewpoints and allowing meaning to emerge.

Based on their individual contexts, phenomenology indicates that reality varies for different people in different contexts, meaning that each participant in this study experienced TOP uniquely and the experiences had different meanings for each woman. Context is defined as that which leads up to and follows and often specifies the meaning of a particular expression and the circumstances in which a particular event occurs (*American Heritage Dictionary* 1992 as cited in Munhall 2012:39).

Heideggerian phenomenology posits that the persons' experiences are shaped by their unique situations or contexts in time (Grove et al 2013:61). Meanings of experiences are established by participants in the context of culture, gender roles, history, beliefs, values and socio-economic state, among others. More importantly, it is in these contexts that individuals are understood. Heidegger's phenomenology refers to this as "being situated" in the specific context and time.

Each individual has situated freedom, not total freedom, in that one has only this much to choose from, depending on what the situation has to offer. For example, some women were forced by their bad economic circumstances to terminate their pregnancies even though they would have loved to keep the baby.

According to interpretive phenomenology, the researcher interviews within the framework of unknowing and intersubjectivity, where the unknower welcomes hearing the experience with all its relational content and meaning for that individual which will in the end be part of the answer to the research question. Through this approach, the participants were given voices. By not imposing the researcher's own knowing, there was a genuine human understanding of another, with the researcher hearing new and different interpretations of reality, searching for meaning in experience, for self and others, and thereby becoming more understanding (Beck 2013:154). Munhall (2012 as cited in Beck 2013:158) adds that during phenomenological inquiry, artistic expressions found in art, film, photography and so on, about the experience, can be investigated as

well. During interviews, the researcher ensured the integration of the life-worlds of each participant.

As Beck (2013:154) refers, an important step the researcher considered was to examine what she thought she knew so that there was no mental clutter or noise when listening to participants speak of their experiences, such that what the researcher heard was not simultaneously cooperated with what she thought she knew from theories, assumptions, presuppositions, and biases. Beck (2013:154) suggests the suspension of the researcher's knowledge about the topic in order to allow participants to speak of their experiences in their own knowing way within their individual situated contexts.

The researcher of the present study, guided by this philosophy, approached stories and dialogues with participants being conscious to be in a state of unknowing and welcomed hearing the participants' experiences and meanings for them, therefore giving them voices. As Beck (2013:154) concludes, interpretive phenomenology offers human meaning, based not on the researcher's interpretation but on the interpretation of experience by those experiencing the phenomenon.

As Munhall (Beck 2013:158) suggests, analysis of the interview should include situated context, expressions by the participants, feelings, metaphors, as well as appearances, and concealments. The researcher made follow-up interviews, where necessary, to ensure capturing the meaning of each participant's narrative.

#### *3.2.1.3 Underpinnings of interpretive phenomenology*

- **Decentring of self and coming to unknowing**

To decentre, the researcher reflected on own beliefs, preconceptions, intuitions, motives, and biases pertaining to TOP and self-forgiveness (Munhall 2012:136). As a research instrument, the researcher cleared her vision and thinking from her assumptions about TOP, from her prior knowledge and from her belief system of Christianity which is against TOP. This was, to the greatest extent possible, achieved through adopting a standpoint of "unknowing", in which the researcher listened with the uncluttered "third ear".

The researcher decentred from presuppositions, beliefs, values, knowledge, thoughts, and ideas about the experience of TOP and attempted to understand without the connection of prior knowledge (Munhall 2012:156). The literature review covered in Chapter 2 only served the purpose of obtaining additional knowledge from which the researcher needed to separate herself.

The researcher recorded in her journal the beliefs, assumptions, preconceptions, what she expected her findings to be and any other noise that would prevent her from hearing clearly participants without interruption (Munhall 2012:137). The researcher also practised interviewing, listening and conversations as preparation for interviewing. Through decentring, a state of unknowing was adopted by the researcher in order to avoid developing confidence which has an inherent state of premature closure (Munhall 2012:138).

The researcher and each participant had a unique perspective of their situated context and who they each are in the world. Interacting together during interviews created the process of intersubjectivity of which the researcher was fully aware (Munhall 2012:139).

- **Situated context**

It is important that the researcher understands the situated meanings of phenomena emerging such that such knowledge is understood within the specific environment or the problem sphere of the participant. This is about the situated context of each participant which includes the life-worlds of spatiality, temporality, embodiment and relational and or contingencies of each person. According to Munhall (2012:159), the researcher needs to describe the situated contexts and the contingencies of all who take part in the study, including the researcher. Context was articulated as follows:

- **Analyse emergent situated contexts**

Heidegger (1962) uses the term ‘thrownness’ to express that the person is always situated. Without prior consultation, human beings are thrown or born into this world during a specific historical time period. They are born into a particular location, culture, economic status, in a body which may be healthy or not, male or female, in a specific country, nationality, family intact or not intact, with a specific world view and language,

have or may not have siblings, friends, support or colleagues. Each person is in context in her “being in the world”, born into a historical time period, a culture, sometimes with experiences that one chose or did not choose. On the contrary, some choices are not available to one and others are not choices but are required within the situated context. For this study, the context was captured as part of the demographic data.

- **Analyse day-to-day contingencies**

Contingencies are about the reason for our action or inaction, decisions or avoidance of decisions, voluntary or involuntary change (Munhall 2012:159). In addition, contingencies are within one’s situated context and life worlds. This unity exerts tremendous influence on the meaning of experience and a persons’ understanding of that meaning. The person’s situated context allows certain actions and at the same time limits others. To truly understand women who terminated pregnancy in this study, the researcher had to personally engage in hearing and seeing these women by processing the data gathered through the lens of those women’s situated contexts (Munhall 2012:159). Follow-up interviews were undertaken, where necessary, to ensure that meaning in each individual’s narrative was captured.

- **Assess life worlds**

Visualising spatiality, corporeality, temporality, and relationality help to understand the person in the world. Spatiality refers to the space or environment in which man finds himself and in which the experience is always embedded or connected. Most of the participants in this study came from informal settlements or from the low socio-economic townships and are mostly in cohabitation environments because they are unmarried.

Corporeality or embodiment refers to the body that we inhabit and that is our access to experience. According to Munhall (2012:159), we *are* our bodies and the mind is embodied in this body.

Perceptions, which are created through the mind, body and contingencies of lives, are the starting point of meaning. In the current study, some women experienced their bodies (specifically their uterus) as shattered and damaged, including their whole

perception of self. Others felt that their embodiment was threatened by failure to have babies in the future, among others.

Meaning and experience cannot exist in isolation, but are interconnected (Munhall 2012:160). Temporality is the time in which we are living. Embodied bodies of humans occupy a space, which is located in time. After the loss of a baby, it is normal for a woman to take time to go through the process of mourning which is meaningful for the woman. However, with TOP, women are generally not expected to take time to mourn and this can have negative effects on their mental health.

People are located in a historical period with its particular contingencies. Temporality is influential to people's behaviour, attitudes, beliefs and our spatiality (where we are located). The country, city or town all have critical influences on women who terminated pregnancy. The laws pertaining to TOP differ with countries and change over time, availability of TOP clinics differ with cities or townships, among others (Munhall 2012:161).

Relationality is about the world in which women find themselves in relation to others. Most women in the present study expressed that they never shared their experience of TOP because they feared being judged, especially by religious people. They end up feeling lonely and depressed (Munhall 2012:128).

- **Perception and experience**

Perception and experience are the original modes of consciousness. Perception is an individual's access to experience in the world. Moreover, perception depends on the context in which something is experienced for interpretation and meaning. Therefore, perception of experience is what matters, not what in reality may appear to be contrary or more truthful. A woman may believe that nothing goes well for her because she is punished for having aborted and therefore killed her unborn baby. To her, that is the reality of her lived experience. Interpretation of the lived experience from the individual's unique perception of an event is critical. What is important from this world-view is not what is happening, but what is perceived as happening (Munhall 2012:128).

- **Natural attitude**

Natural attitude is a mode of consciousness that embraces interpreted experiences (Munhall 2012:128). The experiences and the interpretations of the world by preceding generations are handed down, teaching a great deal about reality in the process. These teachings become the assumptions, unquestioned meanings about phenomena that become deeply ingrained and unquestioned as part of a person's natural attitude toward the world. Anything contrary to the natural attitude for example change, becomes upsetting. The perspectival and the physiological variations associated with a life change are often the result of interference with the natural attitude. In this study, most women expressed that they felt guilty about TOP because it is a violation of their own sense of morals.

- **Being-in-the-world**

Heidegger's phenomenological philosophy views the person as relational. To be human is to "be-in-the-world" because an individual participates in cultural, social and historical contexts of the world. Language, cultural and social practices are handed down to individuals who embody the meanings and interpretations of these practices. This interpretation and self-understanding, handed down through language and culture, are called the background (Munhall 2012:129). Most women expressed that they terminated their pregnancies because they come from poor backgrounds and could not afford bringing up a baby.

- **Meaning**

According to Dahlberg, Dahlberg and Nyström (2011:90), to be human, to have a world to live in, are all integral aspects of meaning. Experiences are therefore the principal aspects of meaning; hence, meaning is symbiotically linked to experiences.

Munhall (2012:129) asserts that meaning is found in the transaction between an individual and a situation so that the individual both constitutes and is constituted by the situation. In this study, the meaning of TOP, coercion, guilt as well as self-forgiveness to women who terminated pregnancies is found in the interaction between these women

and the experience of TOP as well as their context. In this case, the women establish their situation and are established by the situation of TOP.

- **Consciousness**

Consciousness is sensory awareness of and response to the environment through the body as it is capable of feeling, thinking, touching, and hearing among others. Experiencing is made possible through the unity of mind and body and the world is knowable through the subjectivity of being in the world. Any knowing comes through consciousness (Munhall 2012:129).

- **Intersubjectivity**

Interpretive phenomenology involves the possibility of having a similar experience being interpreted differently and with great variability by another being. According to Beck (2013:155), this may be owing to the existence of the mysterious intersubjective space existing between two people where the perception of reality of one meets with another individual's perception of reality. This means that when two or more people come together, there is a melding of different subjectivities (Munhall 2012:27), such that during conversations, each person speaks from their own subjective world with their respective perceptions. Formation of an intersubjective space can lead to the two individuals agreeing, disagreeing or coming up with a consensus. To understand the experience of another using intersubjectivity means the researcher should acknowledge her subjective consciousness and hold them in abeyance, listening with the third ear, without the noise of self (Munhall 2012:27).

In this study, the researcher listened to the women's interpretations of their experiences about TOP, therefore giving these women voices. For the interpretive researcher, when subjectivity followed, the researcher had already purposefully de-centred his or her own worldview about TOP and bracketed her existing knowledge of it to allow participants to explain their own experiences of TOP unhindered by any influence. In this way, interpretive phenomenology gave voice to participants and enabled the researcher to authentically understand them (Munhall 2012:27).

### 3.2.2 Research design

A research design is a plan, structure and strategy of investigation so perceived as to obtain answers to research questions or problems (Burns & Grove 2011:49). It aims at obtaining accurate, objective and valid information in order to answer research questions validly, objectively, accurately, and economically (Kumar 2011:94).

#### *3.2.2.1 Qualitative research*

Glasper and Rees (2013:127) argue that qualitative approach to research is clearly attuned to nursing. It takes a person-centred and a holistic perspective, which is similar to nurses' approach to nursing care. Qualitative approach provides insight into the experiences of patients and clients of health services so that practitioners can begin to appreciate how it is for those concerned and provide sensitive and understanding form of care (Holloway & Wheeler 2010:11).

According to Grove et al (2013:23), qualitative research is a systematic, collaborative, personal, holistic approach of research used to describe life experiences and give them meaning. Kumar (2011:104) posits that the main focus in qualitative research is about understanding experiences, exploring them deeply, and having their meanings explained by the ones experiencing them in their different contexts. This will be the strength of qualitative research for this study as little is known or understood about the relationship between reproductive coercion, TOP in adolescence as well as guilt related to TOP.

The phenomenon under study for this research is deeply rooted in the participants' personal knowledge and understanding of the meaning of their experiences about guilt related to TOP. Experiences were also of a delicate and sensitive nature, involving feelings, values, beliefs, attitudes and perceptions about TOP. Knowing about how participants experienced or made meaning of TOP would need an explorative, descriptive, holistic and a flexible approach.

Qualitative methodologies provide a means of gaining deeper understanding of human behaviours and the factors that influence those behaviours. According to Polit and Beck (2014:487), qualitative design is the most suitable design to use when the researcher

needs to conduct a holistic enquiry based on the realities and viewpoints of participants that are not known at the onset. Narrative enquiry and in-depth interviews were used for data collection in this study and it provided holistic data regarding the experiences related to TOP.

In this study, through a qualitative approach, the researcher investigated experiences of women about TOP in an in-depth and holistic fashion, and collected rich narrative data, using a flexible research design. For the purpose and objectives of this study, a qualitative approach was appropriate to explore the women's experiences about TOP using narratives and in-depth interviews. The data produced through qualitative research was of a holistic nature as it included participants' feelings, behaviours, thoughts, insights, actions, and words (Kumar 2011:104). The richness and depth of explorations of experiences and descriptions yielded one of the greatest strengths of the qualitative approach. Therefore, the researcher was enabled to explore in great detail the experiences of women who terminated pregnancies during adolescence and also acquired a deeper understanding in terms of their own understanding, meanings of their experiences as well as their situations (Babbie & Mouton 2014:271). The emphasis was on the quality, the depth of information and meanings provided by participants.

The use of open-ended questions during face-to-face in-depth interviews was an added advantage of qualitative research as it allowed participants to describe the phenomena in their own words, which assisted the researcher to achieve the research objectives. TOP is laden with stigma and some women will not easily disclose about their experience. Research (Beck 2013:50) has shown that allowing participants to talk, as during in-depth interviews, gives participants a feeling of more control, especially if previous research on them regarded them as being pathological. The interactive nature of qualitative research, especially during interviews, enabled participants to feel free to correct the researcher's attitude, thereby "dismantling" any false assumptions harboured by the researcher.

The power of qualitative research enabled the researcher to find and understand the hidden community of women who terminated their pregnancies and who are generally marginalised or stigmatised and cannot safely expose themselves without social and political risks (Hall & Fields, 2012; Hall & Stevens, 1992 as cited in Beck, 2013:47). In this study, field notes on what the researcher heard, saw, felt, experienced, and

thought about in the course of the interview were written down using the researchers' own shorthand and these observations formed part of the data analysis or were used for verification purposes (Botma et al 2010:217).

On the contrary, qualitative research, through probing, allowed the researcher to explore the depth, the richness, and the intricacy of women's lives or their experiences after TOP thereby causing the researcher to better understand or explain phenomenon of TOP, to guide emerging theories and to build knowledge (Grove et al 2013:57).

Qualitative research has the following contributions, according to Patton (2015:13):

- Issues and subjects are covered in depth and in detail due to the openness of the enquiry and through the use of open-ended questions.
- Interviews are not limited to particular questions and can be redirected or guided by researchers in real time.
- In real life, things seldom go as planned. As unexpected information emerges during the conduction of the study, the direction and framework of research can be revised quickly.
- Data in qualitative research depends on human experience. Researchers study, document, analyse and interpret meanings attached by participants to their experiences. Stories are captured in order to understand people's perspectives. Each captured story opens a window into the world of the participant.
- Complexities and subtleties about the subjects of the research or the topic covered are usually missed by many positivistic inquiries.
- Data are usually gathered from few participants with the result that findings and outcomes cannot be spread to larger populations. However, findings can be transferred to other settings.
- Qualitative research enables the researcher to understand context. Context refers to what is going on around around people, organisations, amongst others, so people's lives and events unfold within larger contexts. Context is important for qualitative inquiry and analysis.
- It enables the researcher to make an analysis of similarities and differences about participants' stories. Constructing contrasts and making comparisons deepens the researcher's understanding of the phenomenon being studied.

For this study, based on the above-mentioned advantages, the researcher selected the design that was appropriate and feasible, given realistic constraints as well as its effectiveness in reducing threats to design validity. The weakness of this research strategy is that it is contextual as the samples are usually small and data are therefore only valid in a specific setting and not meant for generalisation of the findings (Botma et al 2010:195). However, the researcher must describe findings fully, including, among others, research setting, participants, the phenomena studied. In that way, it will allow for transfer of the findings to other settings.

#### *3.2.2.2 Descriptive design*

Through qualitative research, life experiences are described from the perspectives of those experiencing the phenomenon. According to Polit and Beck (2014:57), descriptive research focuses on the causes and the emergence of an experience, putting emphasis on describing subjective human experiences as well as gaining insight into these experiences.

In this study, little was known about this topic and the data collected helped to identify problems with current practices and will therefore guide practice through formulating self-forgiveness strategies that will be useful when counselling women after TOP.

#### *3.2.2.3 Explorative research*

According to Kumar (2011:11), explorative research is conducted to explore an area where little is known about the situation, a phenomenon or an individual in order to get acquainted with basic facts about the situation and create a general picture of conditions. In this study, individual women were requested to tell their stories of their experiences after TOP and the meanings they derived from those experiences. These stories were followed up with one-on-one in-depth interviews to further explore the meanings of those experiences.

#### *3.2.2.4 Interpretive research*

Interpretive research is also called the phenomenological approach, which is an approach aiming at understanding people (De Vos et al 2012:8). A 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. Husserl (1962:39 as cited in Beck 2013:133) observes that phenomenology is a way of freely searching for the essence and the meaning of an experience. In this study, stories, tape-recorded in-depth interviews and field notes were used to get answers to the research questions and to gain a sense of subtle, non-verbal communication from participants.

#### *3.2.2.5 Contextual research*

Qualitative studies are always contextual as the data are only valid in a specific context (Botma et al 2010:195). The findings of this study will be valid in the specific context of the areas served by Laudium Community Health Centre, within Tshwane Municipality and will therefore not be meant for generalisation. The researcher ensured that the descriptions of the experiences of women after TOP were rich, thorough and vivid. The researcher does not have a personal connection to the people who participated in the study but has, over time, observed the frustrations of guilt experienced by some women who terminated pregnancy.

### 3.2.3 Setting and population of the study

#### *3.2.3.1 Setting*

Setting, one of the key design features, is the physical location and conditions in which data collection takes place in a study (Polit & Beck 2014:392). Participants were recruited from a Family Planning Clinic and TOP Clinic of a Community Health Centre (CHC) in Tshwane, Gauteng Province, South Africa. Interviews were conducted in a private office of the Health Centre. One registered nurse runs the Family Planning Clinic and a trained Health Care Worker or other registered nurses assist her when necessary. The Registered Nurse who runs the TOP clinic is trained both in family planning and TOP.

The Community Health Centre serves four areas, namely, Laudium, Centurion, Olievenhoutbosch, Itireleng Informal settlement and a number of other informal settlements.

Regarding race, clients who consult at this Health Centre are mainly Indians and Blacks. Women who participated in this study were mainly Sepedi, Sesotho and Zulu speaking. A few were from Zimbabwe or Nigeria and these were Blacks, though English speaking.

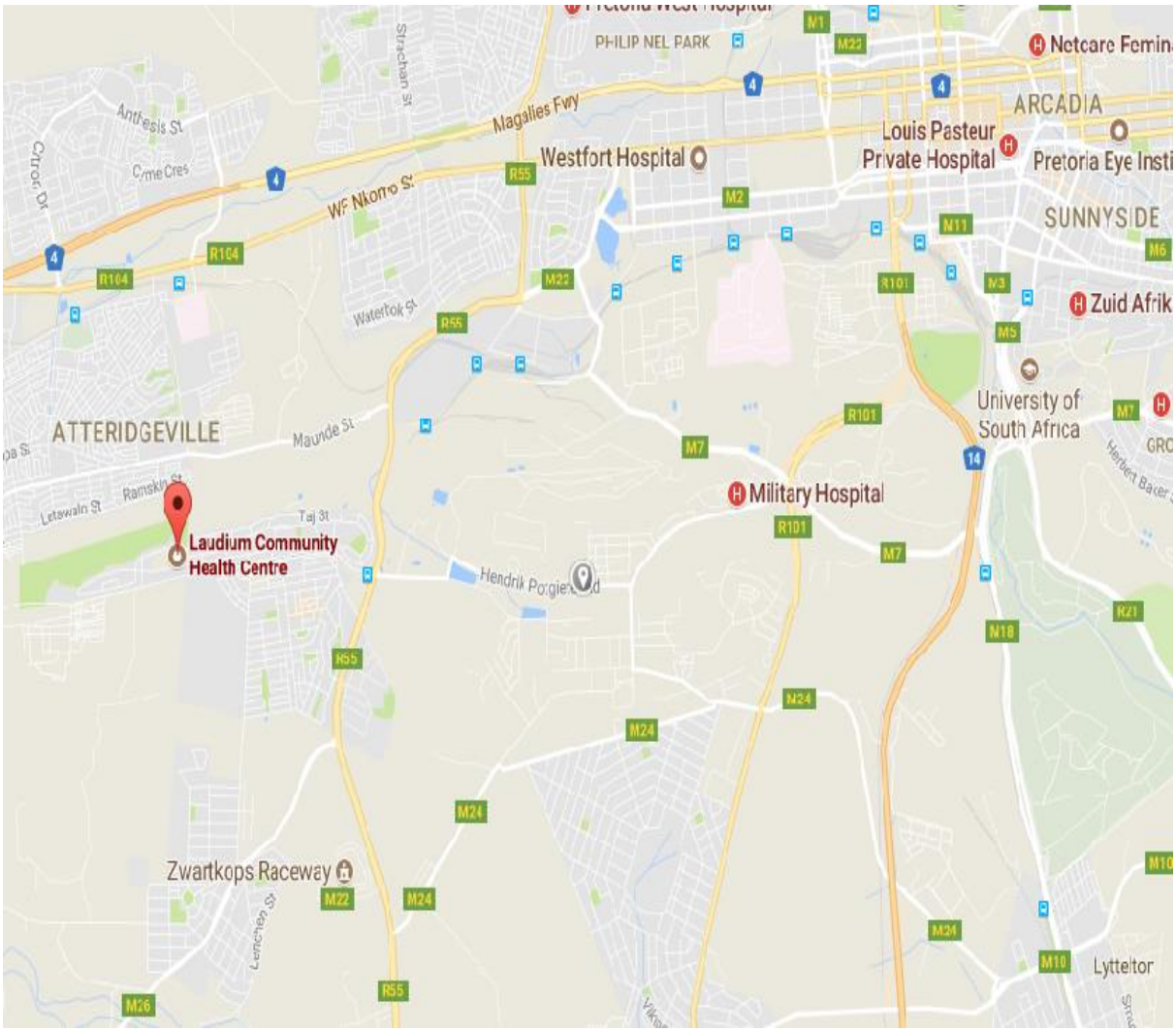



**Figure 3.1 Map of Pretoria showing the setting**

(Adapted from Department of Social Development, Republic of South Africa 2015)

### *3.2.3.2 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). The population is defined by the sample criteria. According to Botma et al (2010:200), it includes individuals, objects or substances that meet the inclusion criteria for the study.

The study population for the current study included Black women from the City of Tshwane. Their ages ranged between 20 to 35 years, and they had terminated pregnancy during adolescence. Representative numbers were sampled from the said entire group as the research sample.

A study (research) population refers to all the elements (individuals, objects or substances) that met certain criteria for inclusion in the study (Burns & Grove 2011:290). The population is defined by the sample criteria. According to Botma et al (2010:200), it should meet the sample criteria. The population for this study was women aged 20 to 35 years, who terminated pregnancy during adolescence.

#### *3.2.3.3 Inclusion criteria*

The target population for this study met the following criteria:

- Women aged 20 to 35 years and underwent TOP by choice.
- Terminated pregnancy during adolescence.
- Are willing to participate in this study.

#### *3.2.3.4 Exclusion criteria*

For this study, the following were to be excluded:

- Women who had a medical diagnosis of being mentally disabled.
- Women who were unwilling to participate in the study.
- Women below the age of 20 and above the age of 35 years.
- Women who were victims of rape at the time of pregnancy.

### 3.2.4 Sample

A sample consists of the people in the population considered for actual inclusion in the study (De Vos et al 2012:199). A sample is studied in order to understand the population from which it is drawn. Therefore, it is important that the sample truly represents the population from which it is drawn. The number of the sample was

adequate when saturation of data was achieved. Saturation of data occurs when no additional sampling provided any new information (Kumar 2011:206). For this study, data saturation was achieved by the 10th participant but the researcher continued with interviewing up to 30 participants, for better understanding of the phenomenon.

#### *3.2.4.1 Sampling method*

Sampling methods are designed to select a subset of the population to represent the entire population (Boswell & Cannon 2014:181). To access the participants, snowball sampling technique and purposive sampling method were used.

- **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, were created. Only criteria-specific participants were included in the sample (Botma et al 2010:230). In this study, only women who were between the ages 20 and 35 years, who were capable of consenting for themselves, who terminated pregnancy by choice during adolescence and were willing to participate, were included in the study. Conversely, exclusion criteria included women who were mentally disabled, women who suffered from serious mental illness prior TOP and who were victims of rape or were below 20 years of age or above 35 years of age.

- **Purposive/judgemental sampling method**

According to Kumar (2011:207), in purposive sampling, the researcher, based on knowledge he/she possesses about the population, judges as to who can provide the best information that is rich and detailed to achieve the objectives of the study. Only women who met the selection criteria, that is, between the ages 20 and 35 years, who terminated their pregnancy by choice during adolescence and who were willing to participate, were selected. They were expressing guilt related to TOP and had all undergone TOP.

- **Snow ball sampling**

Snowball sampling, which is the process of selecting a sample using networks and referrals (Kumar 2011:208), was also used to reach participants who were hard to reach. Each participant was requested to identify other women, up to five per participant, of 20 to 35 years of age, who met the inclusion criteria and the women selected by them became a part of the sample and were interviewed. The disadvantage of the snowball sampling method is that at times only acquaintances of the participants can be accessed and therefore a purposive sampling was also used to reinforce the sampling method used (Polit & Beck 2014:517).

#### *3.2.4.2 Sample size*

In qualitative research, focus is placed on the quality of information obtained from persons, situations or events sampled rather than on the size of the sample (Munhall 2012; Sandelowski 1991). A small sample size can lead to inadequate depth or richness, which may in turn reduce the quality of the findings (Burns & Grove 2011:317). For qualitative studies, the number of participants is adequate when saturation and verification of information are achieved. Although Dahlberg and Dahlberg (201:175) argue that in qualitative research, the decision on the number of interviewees cannot be decided in exact numbers before the start or the completion of a research.

In this study, saturation was reached by the 10th participant but the researcher continued interviewing up to 30 participants for better understanding of the phenomenon.

### 3.2.5 Data collection

Data collection refers to the information the researcher aims to find and the method that will be used to collect data (Botma et al 2010:199). In qualitative research, gathering data is an activity in which researchers seek words, depictions, narrations and other possible expressions of the phenomenon being studied (Dahlberg & Dahlberg 2011:172). For the purposes of this research, narrative, unstructured, in-depth, face-to-face, one-on-one interviews were used to collect data. The stories as well as the

interviews were tape-recorded. Field notes were also taken during storytelling and interviews.

#### *3.2.5.1 Narrative*

As this was a qualitative study, stories collected from participants were the source of data and the units of inquiry (Boswell & Cannon 2014:233). With reference to the present study, telling the stories of their experiences about TOP allowed participants to reflect on those experiences from their own point of view, in order to inform others about the experience. In turn, these stories will serve to inform practice. Each story was part of a wider storied narrative of their lives (Botma et al 2010: 193).

The phenomenological advantage of these storied experiences of people is that they are told by the people themselves, about themselves or as told by others about them (Munhall 2012:421). In this study, the participants themselves told the stories. Meanings that participants gave to their experiences and that shaped their lives were also collected in story form. Through narratives the researcher therefore aims to gather these stories and represent or re-story them to readers (Riessman 2007 as cited in Munhall 2012:421). Factual or verifiable truth of narratives is less important than the stories people build up about their experiences, lives and why they live the way they do. According to Polkinghorne (2007 as cited in Munhall 2012:422), storied evidence is gathered about the meaning experienced by people, whether or not the events are accurately described.

Narration is the process of constructing, reconstructing and communicating human experiences, both the exceptional and the ordinary, such that through it, individuals select events that need relating an inner world of desire and motive to an outer world of noticeable actions and states of affairs. The use of narrative in this study facilitated participants to most effectively make sense of their experiences related to TOP (Gee, 1985:27 as cited in Beck 2013:268). Through narratives, researchers determine how individuals make sense of events in their lives and they come to understand the meaning that participants ascribe to their experiences of events.

Narrative interviews gave participants sufficient control over the course of the interview (Sandelowski 2000b:56). Through probing, as the story emerged, the researcher

encouraged participants to critically reflect on own experiences and look at the meaning of their life story.

The main purpose of narrative interviews was to provide guidance in gathering information about topics that happen to be of interest to the researcher and at the same time are significant events or experiences in the participants' lives. In this study, understanding the experiences of terminated pregnancy in adolescence, reproductive coercion, guilt and self-forgiveness by women was of interest to the researcher and were presumed by the researcher to be significant events in the participant's life.

In data collection, the word "story" is more straightforward than narrative to ordinary people, although story and narrative are not the same thing. Patton (2015:128) notes that one distinction is to treat the story as data and narrative as analysis, which involves interpreting the story, placing it in context and comparing it with other stories. Another difference is that the story is about what happened and the narrative is how the telling of what happened is structured or written within some context for some purpose. According to Patton (2015:128), narratives are analysed to generate knowledge, to explore and deepen understanding of people's experiences.

Humans are story-telling organisms and characters in their own and others' stories and they individually and socially lead storied lives. On the contrary, De Vos et al (2012:313) affirm that the life world of a person can best be understood from her own account and perspective while interrelating the individual's social and cultural worlds. Narrative researchers in turn describe such storied lives, collect and tell stories of them (restory) and write narratives of experience.

Ellis and Bochner (1996 as cited in De Vos et al 2012:313), mention literary, poetic, autobiographical, multivoiced, visual performative and co-constructed representations as other unique ways of expressing experiences. For this study, participants mostly used an autobiographical approach to express their experiences about TOP.

Telling the stories of their experiences allowed participants to most effectively make sense of their world and to reflect on the experience of TOP from their own point of view, to inform others about the experience. Both the participant and the researcher derived meanings related to the experience (Polit & Beck 2014:274).

A narrative interview was used to facilitate the story to be told. It was important to use an unstructured format that enabled the personal narrative to emerge. To ask the right questions required the use of an interview guide consisting of 5 to 7 broad questions. For this study, an interview guide was developed for use during and after story-telling (Annexure E).

*3.2.5.1.1 Structure of narrative*

Each story was told using first person, that is, the women who experienced TOP. Stories were told according to a timeline. The central character playing a major role of each story was the woman who terminated pregnancy, as well as the male partner playing a major and sometimes a minor role in the story.

All the stories told had critical events around decision-making about TOP as well as around the consequences of TOP, the feeling of the guilt of having terminated a life being the most critical. The theme of the stories told was termination of a life and the tone of each story provided clues of the meanings generated by each storyteller or participant. Most of the stories told could be classified as genres of tragedy, whereas a few others as genres of heroism, where the woman felt that she accomplished what she wanted to do (Munhall 2012:425).

Munhall (2012:426) highlights the relational aspects of narratives which, according to Somers (1994 as cited in Watson, Benner & Ketefian 2008: 333) consists of the person's own inner world, the social context, the broad cultural and historical context as well as the researcher's frame of reference. TOP is an individual woman's inner world experience and how each woman experiences it, is affected by her social context and her broad cultural and historical context.

### *3.2.5.2 Unstructured In-depth interviews*

De Vos et al (2012:348) note that unstructured interview is a formalised conversation interested in understanding the experience of participants and the sense they make of that experience. Botma et al (2010:207) define an in-depth interview as an endeavour to understand the experience of life from the participant's point of view and to uncover

the participant's lived world. At the root of in-depth interview was an interest in understanding the experiences of participants about TOP by choice and the meaning they made of those experiences (De Vos et al 2012:348).

In-depth interviewing was used in this study in order to understand the perceptions, opinions, facts, forecasts, and reactions of participants to their experiences of TOP (Botma et al 2010:206). In agreeing, Creswell (2014:14) adds that phenomenological studies should typically involve conduction of interviews.

The main question that was asked: "*Tell me how you have experienced termination of pregnancy during adolescence*". The story that followed was probed where necessary. The follow-up questions during the interview pursued the implications of answers to asked questions.

To maintain consistency, the researcher used an interview guide (Annexure E) which consisted of a set of predetermined, open-ended questions that guided but did not dictate the interview (Botma et al 2010:209). The questions in the interview guide were reviewed with the supervisor of this study and with two participants before the study commenced.

The challenge of interviewing is to maintain a balance between flexibility (for discovery and eliciting the participant's story) and consistency (that is, type, depth, detail of questions as well as the amount of exploration) in data collection. The questions in the interview guide did not block the researcher from probing and 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.

#### *3.2.5.3 Field notes*

According to Botma et al (2010:217), field notes written are a descriptive account of the things the researcher heard, saw, felt, experienced, or thought in the course of the interview. The researcher's inspirations, insights, reactions, and reflections about the personal meaning and significance of what was observed were noted. These observer's

experiences formed part of the data. In this way, the reader of the study findings will be allowed to experience what was observed. Shorthand was used to sketch notes, which were later followed up with more detailed notes. The researcher was disciplined to not impose own preconceptions or early judgements on what was experienced or observed. At the end of each story-telling and interview, the researcher sat down to jot impressions about the experiences, to complete the notes and to record observations.

The researcher captured the participants' body language, facial expressions, changes in position, changes in mood, confidence state, amongst others. Field notes were each dated, and included a description of where the observation took place, what the physical setting was like, any social interactions that transpired, what the researcher knew and thought happened (De Vos et al 2012:359; Patton 2015:387). Field notes were used as part of the data or for verification purposes.

The following observational and personal notes, as noted by Polit and Beck (2014:548), comprised field notes:

- **Observational notes**

Observational notes are about what the researcher observed as objective actions of participants during the interview (Polit & Beck 2014:548). A feeling of sadness and regret was observed whenever participants expressed that they killed their "babies". Most of the time this sadness was expressed through crying, a shaky or low voice or failing to look the researcher in the eyes.

Few participants displayed a confident composure when expressing that they felt in control of their lives by terminating their pregnancies. Others displayed anger at themselves for not protecting their unborn babies or at partners who were not committed to supporting them when they revealed that they were pregnant. A state of helplessness caused by an awareness that one is a "murderer" of her own child, was mostly displayed by a deep sigh, using the expression "*eish"* or a long silence. The prevailing mood in the interview office was mostly that of sadness.

- **Personal notes**

Personal notes refer to the researcher's feelings, emotions, challenges, and experiences in the field (Polit & Beck 2014:549). As the researcher listened to the women, she realised that most of them were sad about the experience of TOP to a point of crying during the interview. Some expressed anger at partners or at themselves. These observations left the researcher emotionally upset, especially when she realised that some women felt they lost their innocence and were guilty and helpless of having murdered their "babies".

For example, one woman expressed: "*I wish somebody could tell me that what I did was not wrong … or that I am not the only one who aborted*". The researcher took control of her emotions and displayed a neutral attitude, even though she felt very sad. The researcher also adopted a sober mood similar to that of the participants.

#### *3.2.5.4 Tape recording*

To make the experiences described by participants more real and substantial, the stories and the interviews were tape-recorded (Greeff 2005:293). Tape recording ensured accuracy of information and it allowed the researcher to concentrate on the story and 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 participants uncomfortable. Although each participant was informed that she had the right to ask for the tape after the interview, none showed any interest.

According to De Vos et al (2012:359), the disadvantage of tape-recording is that the participant may not feel happy being taped and may even withdraw. To avoid this, the recorder was placed inconspicuously and the reason for tape-recording was explained to the participant before the story or the interview began. None of the participants appeared disturbed by the tape-recording.

#### *3.2.5.5 Phenomenological approaches undertaken during data collection*

To enhance quality and credibility, Holloway and Wheeler (2010:219) as well as Streubert and Carpenter (2011:34) recommend the three phenomenological approaches relevant to be followed when conducting interviews. These include reflexivity, grounding and humanisation.

- **Reflexivity**

Reflexivity refers to self-reflection, which is the responsibility of the researcher to examine her influence in all aspects of qualitative enquiry (Streubert & Carpenter 2011:34). The researcher was aware that as an individual she could a unique background of beliefs, values, opinions bring to the investigation as well as professional background that could affect the research progression, influence the findings and credibility of the study (Polit & Beck 2014:326). From the outset of this study, the researcher continually attended to the effect of her impact on the collection, analysis and interpretation of data by recording thoughts about the influence of her previous life experiences, previous readings about TOP, religious beliefs about TOP, among others.

- **Grounding**

Grounding as an approach to interviewing refers to recognising the life-world as the place of origin of the research which is filled with complexity and tensions (Holloway & Wheeler 2010:220). Researchers should adopt a neutral attitude pertaining to their knowledge of the phenomenon being studied. In the current study, the researcher remained unknowing about her, assumptions, theories, values, beliefs and prejudices regarding TOP, so that detailed descriptions are obtained from the participants about the topic (Holloway & Wheeler 2010:220) . Regarding what was observed or heard from the participants during data collection, the researcher remained non-judgemental.

- **Humanisation**

According to Holloway and Wheeler (2010:220), the qualities of human presence are reflected by humanisation and the language of experience, the body, the time and the

space. In the life-world as the focus of phenomenological research, the lived experiences are commonly described by the participants themselves. At the same time the researcher needs to examine what she knew about the phenomenon so that there was no mental clutter when listening to participants narrating their experiences about TOP (Beck 2013:154).

#### *3.2.5.6 Data collection process*

Data were collected during the months of August 2017 and September 2017. Nursing personnel at the community health centre TOP clinic, family planning clinic, antenatal clinic and post-natal clinic assisted with the recruitment and selection of participants, following the eligible criteria. The researcher held brief meetings with nursing personnel of each clinic to inform them about the permission to do the study, the nature of the study, the selection criteria of women aged 20 to 35 years who terminated pregnancy during adolescence, the exclusion criteria, the confidentiality to be maintained, the informed consent that participants would sign with the researcher.

The clinic manager, after identifying a relevant client through routine history taking or through the client's history in her clinic file, explained the study and its aim to a potential participant. If she agreed to be part of the study, the researcher would affirm whether the participant met the inclusion criteria, explain the study to her following the participation information leaflet (Annexure D), secure an interview appointment at a venue suggested by the participant or interview her immediately at the Health Centre.

At the end of the interview, each participant was asked if she knew anyone who terminated pregnancy during adolescence (at age 10 to 19 years) and if the answer was yes, they would be asked to recruit the person for the study. The researcher would make a telephonic follow up to arrange an interview with the potential participant at the Health Care Centre.

To ensure privacy and confidentiality, the researcher interviewed participants in a private office at the Health Centre, at a time agreed upon by participants. When meeting at the Health Centre was not possible, the researcher used an agreed upon private area for the interviews. The researcher reimbursed the participants for their transport money and this was clarified to the participants by the researcher when making appointments.

Before each interview, the researcher explained the consent form to each participant, after which the participant signed the consent form, and had the participant provide demographic information. The opening question was asked afterward, in order to assist the participant to tell the narrative about her experiences regarding TOP and thereafter an in-depth interview was resumed.

The interest during in-depth interview was to understand the experience of these women and the meaning they made of that experience. Botma et al (2010:207) note that all in-depth interviews are interactional events which deeply and unavoidably implicated in creating meanings that seemingly reside within participants.

The format, as suggested by Greeff (2005:295), as cited by Botma et al (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 was confirmed.
- Reminded the participants that they were free to withdraw at any time.

If there was need for counselling, participants would 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 storytelling and interviewing. Before storytelling and interviewing, participants were requested to write down their 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, as well as mental health before TOP.

The main question that was used to get the participant tell her story was: *"Tell me how you have experienced TOP during adolescence"*. 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. In addition, 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 participant 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 as well as Zulu. The language used was dependent on the participant's choice. More importantly, the consent form, though written in English, was thoroughly explained in Sepedi, Setswana, Zulu, or English, depending on the participant's language of choice.

#### *3.2.5.7 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 on two participants, a month before commencement of the actual data collection. The main question was found to be adequate as it allowed participants to talk broadly about their experiences. It also became clear that an hour was adequate time duration for the storytelling and the interview. The two participants that were interviewed in the pilot study formed part of the final participants for the study and the information they gave formed part of the data.

### 3.2.6 Data analysis

Data analysis is the systemic organisation and synthesis of research data (Polit & Beck 2014:378). The process of data analysis in this study involved making sense of narratives and observed data. It involved preparing data for analysis by making transcriptions from tape-recorded interviews, conducting different analyses, immersing oneself into understanding data, analysing each story, as well as making an interpretation of the larger meaning of the data (Cresswell 2009:183 as cited in Botma et al 2010:220).

In this study, as in qualitative research, data preparation and reading through transcripts as well as analysing the interviews while they were still fresh was done concurrently with collection of data. In this way, the researcher could address data collection challenges immediately (Botma et al 2010:220).

The researcher transcribed data verbatim after each interview in preparation for analysis. Analysis was done following Colaizzi's seven steps (Polit & Beck 2014:309).

#### *3.2.6.1 Data analysis according to Colaizzi's seven steps*

The researcher familiarised herself with data by reading the texts and field notes many times while doing data collection, developing ideas about the phenomena of TOP, therefore doing some data analysis for initial understanding of the data's meaning. Accordingly, the researcher immersed herself in the data in order to know them thoroughly (Botma et al 2010:226). Data were stored electronically following each interview.

After each data collection process the researcher listened to the recorded interviews objectively in order to critique her own interviewing style, so that improvements can be made in subsequent in subsequent interviews (Polit & Beck 2014:544). Transcription of data was done verbatim. An experienced independent coder was engaged to check the quality of the transcripts and to give transcripts feedback. Colaizzi's seven steps were used (Polit & Beck 2014:309). Step seven was replaced by on-going probing for member checking as suggested by Polit and Beck (2014:591).

**Table 3.1 Data analysis used according to Colaizzi's seven steps**

| **Colaizzi's steps of data analysis** | **Data analysis activities in the current study** |
|---|---|
| 1 To acquire a feeling for the protocols, the researcher started reading the protocols from transcripts several times (Polit & Beck 2014:309). | • The researcher read all the verbatim transcripts many times. |
| 2 As each written data is read, significant statements are extracted (Polit & Beck 2014:309). | • Reading each written data several times enabled the researcher to gain a deeper understanding of the text, to extract noteworthy statements and to organise new meaning. |

| Colaizzi's steps of data analysis | Data analysis activities in the current study |
|---|---|
| 3 New meanings of each noteworthy statement were formulated (Polit & Beck 2014:309). | • New meanings from significant statements were attached to the statements made by participants<br>• Reflecting on essential themes |
| 4 Formulated meanings should be organised into clusters of themes and sub-themes<br>• It was important to validate these themes and subthemes by referring to the original protocols.<br>• Discrepancies among or between the various clusters were noted and the temptation to ignore data or themes that did not fit was avoided (Polit & Beck 2014:309). | • Themes and sub-themes were formulated and these were validated by comparing them with the original protocols.<br>• Examined various sections of the text and if similar, combining them. This was done to find similarities and finer differences in the data.<br>• All themes were taken into consideration, even those that were misfits. |
| 5 Integrate results into an in-depth description of the phenomenon under study (Polit & Beck 2014:309). | • Phenomenon of TOP was fully described. |
| 6 Writing and re-writing themes and sub-themes. These were supported by quotes to further verify the findings (Polit & Beck 2012:556). | • The whole text was documented and this allowed for deeper interpretation of themes and sub-themes. |
| 7 On-going probing and validation of the findings done with participants (Polit & Beck 2014:591). | • Throughout the data collection process and interviewing, probing was done to ensure accuracy of the meaning and interpretation of the experiences. |

### 3.2.7 Strategies to enhance quality

A variety of strategies has been proposed to address the challenges of enhancing quality in qualitative studies. The strategies have been arranged according to different phases of the study, namely, throughout the study, data generation, data analysis and presentation of findings. The strategies follow Lincoln and Guba's criteria (Polit & Beck 2014:32).

### 3.2.8 Ethical considerations

Nursing research requires expertise, diligence, truthfulness as well as integrity. Ethical conduction of this research started with the identification of the research topic and continued through the publication of the study (Grove et al 2013:159). Ethical research is essential to produce a rigorous evidence-based practice for nursing because as

practitioners, nurses must be able to justify the reasons for practice. Ethical considerations in research are principles that are meant to protect research participants (Williams 2014:225). For this study, the researcher first sought permissions from different organisations and then adhered to ethical principles as outlined in the Belmont Report (DeLanda 2009), following the framework of Lincoln and Guba (Polit & Beck 2014:323).

The researcher adhered to the following principles of ethical conduct:

#### *3.2.8.1 Trustworthiness*

Trustworthiness is the degree of confidence and integrity 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). Polit and Beck (2014:394) added to the list, the criteria of authenticity.

##### *3.2.8.1.1 Credibility*

Credibility is the degree of confidence that qualitative researchers have in their data and analyses. It is useful for evaluating integrity and quality in qualitative studies (Polit & Beck 2014:394). De Vos et al (2012:419) add that the goal of credibility is to demonstrate that the enquiry was conducted in a manner that ensured that the subject has been accurately identified and described so that there is confidence in the truth of the data and in their interpretation.

Credibility or the truth-value of data and data analysis (Boswell & Cannon 2014:237) can be achieved in a study through several methods. In light of the recommendation by Cresswell (2009:91 cited in Botma et al 2010:231) multiple strategies should be used to ensure validity, the following strategies were employed to ensure rigour and increase the credibility of this study:

- **Triangulation of different methods**

Triangulation is a strategy used in research to enhance credibility by crosschecking information and conclusions, using multiple data sources and research methods or

researchers to study a phenomenon or using multiple theories and perspectives to help interpret the data (Hauser 2015:395). According to Boswell and Cannon (2014:250), triangulation is used for substantiating data from multiple methods. In this study, triangulation allowed the researcher to fully understand the phenomenon of guilt related to TOP through validation or enhancement of data.

To enhance credibility through triangulation, the following methods were used:

- ***Method triangulation***

Triangulation of different methods involves using multiple methods of data collection to investigate the same phenomenon or concept (Polit & Beck 2014:543). As Botma et al (2010:87) note, it is important to triangulate because each research method has its own inherent weaknesses and using appropriate triangulation techniques correctly will increase the overall validity of the study and enhance credibility (Hauser 2015:395).

In this study, to ensure saturation of data and to capture a more complete and insightful description of the phenomenon of guilt related to TOP, the researcher used multiple data collection methods, including participants' narratives, tape-recorded in-depth interviews, asked a grand tour question and field notes.

- ***Theory triangulation***

Theory triangulation involved gaining and using multiple perspectives from other researchers or from published literature during literature review in chapter 2 (Hauser 2015:395).

- ***Investigator triangulation***

Investigator triangulation involved the use of an independent coder to analyse and interpret data. The supervisor of the study guided the whole process followed in undertaking this study (Hauser 2015:395).

- **Member checks**

According to Hauser (2015:395), researchers use member checking when they ask participants to review and comment on the accuracy of transcripts, interpretations or conclusions. Accordingly, 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 was carried out in order to verify if the results reflect participant's actualities. In addition, member checking was done throughout data collection, and allowed 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 each participant: *"Is what I just read to you a true reflection of what you have just said?"* When necessary, a follow-up interview and discussion with participants was done in face-to-face discussions.

- **Thick and contextualised descriptions**

According to Polit and Beck (2014:331), thick descriptions refer to a rich, thorough and intense description of the research context, the people who participated in the study and the experiences and processes observed during the inquiry. For the present study, clear and textured descriptions, with inclusion of verbatim quotes from study participants, as well as detailed descriptions of the setting and many perspectives of the theme contributed to the authenticity of the study. These were provided by the researcher and it included data about rich descriptions by participants regarding their experiences of TOP was collected by the researcher. For the purpose of this study, an interpretive approach also called a phenomenological approach, guided the researcher (De Vos et al 2012:8).

Edmund Husserl (1913:40 as cited in Beck, 2013:133), in philosophising about phenomenology, emphasised the importance of elimination of unexamined presuppositions when looking at things, and avoiding reverting to the old viewpoints. Through reduction, the researcher put aside (bracketed) what she already knew about the phenomenon of TOP to avoid imposing her past knowledge or experience upon it. More importantly, phenomenological reduction enabled a radical exploration of the

essence of experiences of women who terminated their pregnancies during adolescence. The researcher tried as much as possible to render contextualised description of the phenomenon by including the form of the findings.

- **Researcher credibility**

Researcher credibility is an aspect of credibility (Polt & Beck 2014:331) because researchers are data collectors as well as facilitators of the analytic process. Patton (2002 as cited in Polit & Beck 2014:331) argues that trustworthiness is enhanced if information about the researcher and her credentials, as well as her personal connections to the topic, the participants or the community under study is contained in the research report. The researcher should also express her efforts to be reflexive about taking own prejudices into account (3.2.2.6).

The researcher of this study is a Motswana, belonging to the Christian faith and she is familiar with Black African cultures and values related to pregnancy, TOP and death. The researcher was also familiar with the participants' languages of Setswana, Sepedi, Sesotho and Zulu and this enhanced communication during interviews. The researcher is a Registered General Nurse, with a focus on Community Health Nursing, Nursing Education and holds a Master's degree in Nursing Science. She also completed a Primary Health Care module on SRH of which TOP was an aspect.

- **Reflexivity/clarifying the bias of the researcher**

Reflexivity involves attending continually to the researcher's effect on the collection, analysis and interpretation of data. It involves awareness that the researcher as an individual brings to the inquiry a unique background, set of values, and social and professional identity that can affect the research process (Polit & Beck 2014:326). Accordingly, this was done by maintaining a reflexive journal (3.2.5.6). From the outset of the study and henceforth, the researcher recorded her own thoughts about the impact of previous life experiences, previous readings, beliefs, and values related to TOP. This self-interrogation enabled the researcher to be well positioned to probe deeply and to grasp the participant's experience of TOP through the lens of participants.

- **Negative or discrepant information which run counter to themes**

The researcher ensured that any contrary information found was discussed with participants or with the study supervisor. Discussing contrary information added to the credibility of the study.

- **Prolonged engagement and persistent observation in the field**

Polit and Beck (2014:325) argue that prolonged engagement is the investment of sufficient time collecting data in order to have in-depth understanding of the culture, language or views of the people and to ensure data saturation. Accordingly, the researcher spent sufficient time (over eight weeks) conducting in-depth interviewing and collecting data to understand the culture, language, the experiences and views about TOP. Extended contact with participants served as means of controlling the biases that might result in premature conclusions. Sustained involvement also helped build a trusting relationships and rapport that were necessary to elicit accurate and thorough responses (Houser 2015:395).

Persistent observation is about the salience of the data being collected (Polit & Beck 2014:325). The researcher focused on characteristics of the situation that were relevant to the phenomena being studied for example, sadness related to the loss of the aborted ”baby” expressed through crying. These observations were recorded as field notes. Prolonged engagement provided scope whilst persistent observation and interviewing provided depth.

- **Peer review and debriefing**

Peer review and debriefing is another quality-enhancement strategy involving external validation. Peer debriefing involves sessions with peers to review and explore aspects of enquiry (Polit & Beck 2014:330). It exposes researchers to the searching questions of others who are experienced in the phenomenon being studied. Peer debriefers addressed the following questions:

- Evidence of research bias.
- Adequate portrayal of the phenomenon by the gathered data.
- Identification of important themes.
- Strategies to remedy any important omissions.
- Apparent errors of fact or possible errors of interpretation.
- Presence of competing interpretations.
- Are themes and interpretations knit together into a useful conceptualisation of the phenomenon? (Polit & Beck 2014:330).

In peer debriefing sessions, researchers presented written or oral summaries of the data and emerging themes of the study as well as researchers' interpretation of the data. 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 the supervisor of this study and to one expert in qualitative research.

A study is subjected to peer review when experts in qualitative research evaluate the quality of the study and determine whether it warrants presentation in a professional journal (Houser 2015:5). It involves sessions with peers to review and explore various aspects of the enquiry (Polit & Beck 2014:330). The supervisor of this study continuously asked questions about the different aspects of the study. Accordingly, peer review and debriefing were used to enhance accuracy of the account and for objective assessment of the study.

*3.2.8.1.2 Dependability*

Polit and Beck (2014:585) describe dependability of qualitative data as the extent to which stability of data can be relied upon even under conditions of dissimilar occurrence as the original research study process. 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. For analysis, interpretation and assessment of the manner in which the findings were arrived at, an independent coder was engaged. Transcripts were also given to an independent coder who did not participate in this study. Therefore, the independent coder and researcher met to agree on themes and sub-themes. The researcher also endeavoured to stick to the research problem and stay focused.

#### *3.2.8.1.3 Confirmability*

According to Botma et al (2010:233), conformability 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. In the present study, the researcher conducted one-on-one interviews, which ensured that participants' voices were reflected in the findings (Polit & Beck 2014:585). Field notes were also taken and integrated in data analysis to back up the findings. The researcher combined different data collection methods such as field notes, tape recordings, interviewing, letter writing, among others, and checked findings with participants, that is, member checking. Data were transcribed verbatim to confirm that data collected originated from participants (Moloko-Phiri 2015:52).

#### *3.2.8.1.4 Transferability*

Transferability refers to the degree to which the findings from data can be transferred to other settings under similar conditions (Polit & Beck 2014:585). It is the ability to generalise from the findings to larger populations (Botma et al 2010:233). The researcher 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.

#### *3.2.8.1.5 Authenticity*

Authenticity is the extent to which the researcher fairly and faithfully shows a range of different realities. It conveys participants' lives as they are lived. It enables readers to develop a heightened sensitivity to issues being depicted, with a sense of feeling, experience, language, and context of those lives (Polit & Beck 2014:323). The present study was guided by a phenomenological philosophy, which enhanced authenticity. The participants were allowed to express their voices.

*3.2.8.1.6 Permission*

In preparation to conduct this study, the researcher first sought permission from the Research Ethics Committee, Department of Health Studies, University of South Africa. The application was reviewed in compliance with Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on the 7 December 2016. Finally, Unisa Ethical Clearance Certificate was obtained from Unisa's Research Ethics Committee, Department of Health Studies (Annexure A).

Permission was also sought from the Department of Health for the researcher to conduct the study through a Community Health Centre in Tshwane, and to recruit participants from the same Health Centre (Annexure B). Permission was granted by Tshwane Research Committee, Department of Health, and a Clearance Certificate was granted on the 28 July 2017 (Annexure C). More importantly, the Community Health Centre in which data for this study was collected gave permission for the researcher to recruit participants from the centre and to use one of the offices in their premises for conduction of interviews.

Over and above obtaining permission, the Belmont Report articulated the following ethical principles on which standards of ethical research conduct are based (DeLanda 2009):

*3.2.8.1.7 Beneficence*

Beneficence is an ethical principle that seeks to maximise benefits for study participants and prevent harm (Polit & Beck 2014:375). The principle of beneficence required the researcher to do good "and above all, to do no harm" (Grove et al 2013:172). In nursing science and practice, the principles of "always doing good" (beneficence) and "doing no harm" (non-maleficence) to patients is the foundation of effective health service provision. For this study, in doing good to the participants, the researcher tried to minimise risks by asking for their consent. Moreover, the researcher observed emotional upsets during the interviews and demonstrated respect by having a relaxed facial expression and by not being judgemental.

To adhere to this principle, the researcher needed to secure the well-being of the participants, who had the right to protection from discomfort and harm, be it physical, emotional, spiritual, economic, social, or legal. Botma et al (2010:22) underscore 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:

- **The Right to Freedom From Harm and Discomfort**

**Physical harm** in this study was fatigue as the method of data collection for this study was face-to-face, one-on-one, in-depth interviewing, where probing was done and where the participants were expected to recall past and sensitive experiences about their TOP experiences. During the interviews, the researcher provided a drink and a light snack to help overcome fatigue.

**Psychological or emotional harm** may be owing to self-disclosure, introspection or having to reveal deeply personal information that causes the participant embarrassment, (Botma et al 2010:22). The researcher exercised greater sensitivity where highly personal areas were explored (Polit & Beck 2014:83). The researcher made prior arrangements with the Unit Manager of the TOP clinic at the Health Centre for referral of clients who experienced intense emotional manifestation of anxiety, anger, or sadness, for counselling. None of the participants used these services. However, when some of the participants spoke with a broken voice, 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 could have been realised in stigmatisation of these women who terminated pregnancy. The researcher avoided interviewing participants at their homes as this would raise suspicions from family members where the participant had never disclosed TOP. All interviews were carried out at the Health Centre office, away from the TOP clinic, where they would not be noticed. Where necessary, the meetings were held outside working hours.

**Economic or financial harm** involves the burden of direct or indirect financial costs to the participants (Botma et al 2010:23). This could include costs incurred for travelling to the Health Centre, 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. In addition, a drink and a snack were provided to the participant. Interviews lasted between 45 minutes to one hour. Dignitary harm occurs when individuals are not treated as persons with their own values, preferences or commitments, but rather as mere means, not deserving of respect (Botma et al 2010:23). 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 were free to discontinue their participation at any time. Only thereafter, a consent was signed.

- **The right to protection from exploitation**

Being involved in a study should not disadvantage participants. Participants need to be assured that their participation or information they provide will not be used against them in any way (Polit & Beck 2014:83). In the present study, women were assured of confidentiality and that their names will not be exposed to their church authorities or to people who know them. The relationship that study participants enter into with the researcher who is a professional nurse was not exploited (Polit & Beck 2014:83). Moreover, the nurse researcher already had a nurse-patient relationship with the participants and the researcher exercised special care to avoid exploiting that bond. The researcher ensured that women's consent to participate in this study did not result from their understanding of the researcher's role as a nurse, but as researcher.

According to Polit and Beck (2014:83), qualitative researchers are in a better position to do good rather than just to avoid doing harm because of the close relationships they often develop with participants. During one of the interviews of this study, when asked what she wished should be done so that she forgets about the guilt of TOP, one participant shared:

> "…I wish to know that what I have done is not a bad thing…I made a mistake to myself…I wish to be told by a different person, a nurse…or you…heish…because you will tell me the truth, you won't tell me what will break my heart or cause my heart to sink…because right now I don't know the truth, I am just hanging in the air."

*3.2.8.1.8 Respect for human dignity*

This is the second ethical principle mentioned in the Belmont Report (DeLanda 2009). It includes:

- **The right to self-determination**

This principle infers that potential participants have the right to decide voluntarily whether to participate in a study, without risking punishment or prejudiced treatment (Polit & Beck 2014:84). It further means that participants have the right to ask questions, to refuse to give information or to withdraw from the study. In the present study, participants were informed that they are not coerced to participate. More importantly, no incentives were offered to participants as these would place subtle pressure on women to participate.

- **The right to full disclosure**

Respect for human dignity requires full disclosure. To ensure full disclosure, the researcher fully explained the aim of the study to each participant, explained the person's right to refuse participation or to stop the researcher from continuing with the interview if the participant was not feeling well. Any possible risks and benefits related to the study were also explained (Polit & Beck 2014:84).

In the present study, there were no physical risks. Participants did not experience any psychological harm although some experienced emotional upsets and were tearful, as this was a sensitive topic. In this case the researcher paused the interview, provided a tissue for wiping the face, reassured them and waited until the participant has regained her composure. Participants who experienced this stated that they did not see a need to be referred for counselling.

*3.2.8.1.9 Justice*

The principle of justice holds that human subjects should be treated fairly and should receive what they are owed or due (Grove et al 2013:172), as well as their right to privacy (Polit & Beck 2014:85).

- **The right to fair treatment**

Selection of subjects and their treatment was done fairly. In this study, the subjects who met the selection criteria were identified at the TOP clinic, the family planning clinic as well as the post-natal clinic through the respective unit managers. Thereafter, the Unit Manager explained briefly about the research and fixed an appointment if the potential participant agreed to be part of the sample. Participants were not selected based on their vulnerabilities but on the research requirements (Polit & Beck 2014:84).

Regarding fair treatment, the researcher and the participants had a specific agreement about what the subject's participation would involve, and what the role of the researcher would be. The participants were treated fairly throughout the study and the agreements made were respected. For example, appointments were kept, punctuality was maintained, the data collection process was carried out as agreed, snacks were provided to prevent exhaustion, as promised, and transport money was reimbursed as promised.

- **The right to privacy**

Participants have the right to expect that any data they provide will be kept in strict confidence because research with humans almost always intrudes into personal lives (Polit & Beck 2014:85). Maintenance of confidentiality was explained to each participant before signing the consent. Interviews were conducted in a private office at the Health Centre. This was always agreed upon with participants before interviewing.

*3.2.8.1.10 Informed consent*

When equipped with sufficient information, potential participants were requested to provide a signed informed consent for participation. All the participants who were involved in giving the informed consent had, as defined by the Nuremberg Code, the legal capacity to give consent and to exercise free power of choice. Therefore, their participation in this study was without the intervention of any force, fraud, deceit, duress, over-reaching or other ulterior form of constraint or coercion. Moreover, participants had sufficient knowledge and comprehension of the components of the subject matter involved to enable them to make an understanding and enlightened decision (Levine 1986:425 as cited in Grove et al 2013:178).

Through an informed consent, subjects were made adequately aware of the type of information the researcher wants from them, why the information was being sought, what purpose it would be put to, how they were expected to participate in the study, and how it would directly or indirectly affect them. The informed consent signed by participants disclosed all the essential information about the study. Individuals who gave consent were autonomous and were capable of understanding and weighing the benefits and risks of the proposed study. According to Grove et al (2013:178), consent information was verbalised in lay language, without the use of biased terms or jargon that could coerce subjects into participating in the study. The consent was voluntary and without pressure (Annexure D).

Participants agreed to participate in this study after being informed of its purpose, procedure, risks, benefits, alternative procedures, and limits of confidentiality. For the purpose of this study, the informed consent included and emphasised the concept of decision-making capacity, voluntarism and protection of the participants' privacy. Information about the publication plans of the results was also disclosed.

The unintended risk, such as psychological or emotional distress brought about by disclosing personal issues to the researcher was explained. The benefit of the study was that findings of the study related to nursing interventions on women undergoing TOP would be more beneficial for nursing care. Even though the consent was written in English, the researcher switched to one of the indigenous languages such as Setswana, Sepedi or Zulu as necessary.

- **Refusal and withdrawal from the study**

Participants were informed that they had the right to refuse to participate in the study and that they could withdraw from it at any time during its course. 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.

*3.2.8.1.11 Autonomy and confidentiality*

This is about the principle of respect for persons, which holds that persons have the right to self-determination and the freedom to participate or not to participate in research, i.e. have the right to autonomy and confidentiality (Grove et al 2013:172). Based on the right to privacy, the participant were informed of the right to anonymity and the right to assume that the data collected will be kept confidential. Anonymity exists if the subject's identity cannot be linked, even by the researcher with his or her individual responses (APA 2010 as cited in Grove et al 2013:172).

Confidentiality as the researcher's ability to manage private information shared by the subject that must not be shared with others without the permission of the subject, was ensured.

It is grounded in the following principles:

- Participants can share personal information to the extent they wish and are entitled to hold secrets.
- One can choose with whom to share personal information
- People who accept information in confidence have an obligation to maintain confidentiality.
- Researchers have a duty to maintain confidentiality that goes beyond ordinary loyalty.

In this study, the identity and the information of participants were kept confidential and this was explained to participants before they signed informed consent. The interviews were conducted in a private office provided at the hospital, where only the researcher

and the participant were present at an appointed date and time. Moreover, the information provided by respondents was kept locked and pseudonyms were used to maintain anonymity. Even though pseudonyms were used, the researcher and the participant, where necessary, could agree on a second visit for verification of data. Participants' names were not mentioned during recording.

Participants were informed on an ongoing basis that they had the right to withhold information. Furthermore, participants were also informed that other researchers would be examining their data to ensure credibility of the study findings (Munhall 2012 cited in Grove et al 2013:173).

The researcher observed the following guidelines provided by Botma et al (2010:17):

- 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 were used.
- Access to confidential information was limited to the researcher, supervisor of the study and the qualitative research expert.
- All data information was saved on a memory stick and locked away together with the tape recordings of the interviews. On conclusion of the study, all tapes and other identifiable data will be kept safe for five years as the period specified by the university and will thereafter be destroyed.

*3.2.8.1.12 External auditor*

An external auditor/s appointed by the University of South Africa, who was not familiar with this study, provided an objective assessment of the study. According to Polit and

Beck (2014:330,) it enhances trustworthiness of the data and the meanings attached to them.

#### *3.2.8.1.13 "Ownership" issues of the narrative*

According to the Colorado University EDRM-600, narratives may involve people or events that the researcher does not have permission to communicate owing to the issue of ownership, which can lead to delays or unintended consequences for the research (Sandelowski 200b:338). There were no issues related to ownership of the narrative in this study and the researcher secured anonymity and confidentiality and this was explained as part of the informed consent. In addition, the researcher ran the risk of transferring their own perspective for that of the participants through the act of "restorying", which can unintentionally cause the loss of the participants' "voice". Colorado University EDRM-600 (Sandelowski 200b:336). In this study, the researcher used direct story lines from participants when analysing data.

## 3.3 CONCLUSION

This chapter covered the research design, research methods, the setting where research was conducted, population, sampling, data collection, data analysis, credibility, and ethical considerations observed during the study. The next chapter will discuss research findings.

# CHAPTER 4

# DATA ANALYSIS, FINDINGS AND LITERATURE CONTROL

## 4.1 INTRODUCTION

The previous chapter provided an overview of the research methodology that the researcher used in this study. Measures to ensure trustworthiness as well as ethical considerations, including methodological issues encountered, were included in this chapter. A qualitative approach, guided by interpretive phenomenology proposed by Heidegger (1962) guided this study.

The current chapter presents research findings in terms of themes and sub-themes that emerged from the analysed data. The report is presented according to the following sub-headings: biographic information of participants (context), history of TOP, mental state before TOP and the research findings. In the end, the researcher strived to interweave the thematic parts together into a unified whole that provided an inclusive structure to the data.

## 4.2 DATA GATHERING AND ANALYSIS

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

### 4.2.1 Sample description

Participants were selected according to the criteria specified in section 3.2.3.3 and 3.2.3.4. For purposes of confidentiality and anonymity, numbers were used in the place of names of participants. The study sample consisted of women between the ages of 20 to 35 years, who terminated pregnancy during adolescence at ages 10 to 19 years. A total of 30 participants were interviewed.

### 4.2.2 Data gathering

Data were gathered using in-depth, one-on-one, unstructured interviews (3.2.5.3). Collection of data was conducted during August and September 2017. Two participants, through other participants who were already interviewed and were their acquaintances, were recruited using the snowball method. The rest, that is, 28 participants, were recruited from one Health Care Centre while they were seeking antenatal care, post-natal care, family planning, or post-TOP follow-up care. Interviews were conducted in an office at the Health Care Centre, at a time and date agreed upon with participants. Field notes (3.2.5.4) regarding observations about the participants' reactions during the interviews and about the natural setting where the interviews were conducted were noted.

### 4.2.3 Data analysis

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2014:378). It involved reducing the volume of raw information, sifting significant facts from trivialities, identifying significant patterns, and constructing a framework for communicating the essence of what the data revealed (De Vos et al 2012:397).

Tape-recorded data was transcribed verbatim and edited for accuracy. The researcher engaged an experienced independent coder as well as the supervisor of this study to check the quality of the transcriptions and to give feedback. The researcher and the coder read each transcript several times to gain an understanding of participants' experiences.

In the present qualitative study, data analysis commenced during data collection and continued soon after data collection. Data were analysed following the phenomenological method of Colaizzi (1973; 1978 as cited in Polit & Beck 2014:405). Colaizzi's method includes the features of both Husserl's and Heidegger's philosophies. Colaizzi maintains that description is vital to discovering the essence and the meaning of a phenomenon. However, Colaizzi also subscribes to Heideggerian view of reduction. Individual phenomenological reflection about the phenomenon being studied is one

approach Colaizzi offers for assisting researchers to decrease their biases and presuppositions on their studies (Polit & Beck 2014:405).

The seven steps of the phenomenological method of data analysis developed by Colaizzi (1978 cited in Polit & Beck 2014:309) were followed. This method is designed to uncover the fundamental structure of a phenomenon, which is the essence of an experience. An assumption of phenomenology is that for any phenomenon, there are essential structures that comprise that human experience. Therefore, by examining specific experiences of the phenomenon being studied can their essential structures be uncovered.

The order of Colaizzi's steps is as follows: written protocols, significant statements, formulated meanings, clusters of themes, exhaustive descriptions, and fundamental structure. From each participant's description of the phenomenon of TOP, significant statements, which were sentences or phrases that directly described the phenomenon, were extracted (Annexure F). For each significant statement, the researcher formulated meaning from what participants said to what they meant (Polit & Beck 2014:407). Formulated meanings were related to original transcripts. This step of formulating meanings from statements shows Colaizzi's connection to Heidegger.

The next step entailed organising formulated meanings into themes by an independent coder and these were verified with the researcher and the supervisor of the study. Thereafter all the results were combined into an exhaustive description. This step was followed by revising the exhaustive description into a more condensed statement of the identification of the fundamental structure of the phenomenon of TOP. To validate how well the aspects of their experiences were captured, two women who participated in the study were asked to member-check the fundamental structure of the study. They agreed with the structure and new data that they shared were incorporated in the findings.

The findings of the study and its interpretations were grouped into themes and sub-themes. After analysis of data by an independent coder, a meeting between researcher and the coder was arranged to compare and reach consensus about the findings.

The following themes were agreed upon by the independent coder and the researcher:

- Theme 1: Transgressing one of nature's strongest instincts: The mother's protection of her young
- Theme 2: Unplanned pregnancy
- Theme 3: Intra- and Interpersonal relationships
- Theme 4: Experience of caring by health care professionals

## 4.3 FINDINGS OF THE STUDY

Findings of the study included biographical data of the sample, the history of the pregnancy, and mental health before TOP, the themes and the subthemes that emerged from the qualitative data.

### 4.3.1 Biographic characteristics of participants

Table 4.1 depicts the Biographic profile of participants, Table 4.2 shows History of TOP, Table 4.3 Mental Health before TOP and Table 4.4 Personality characteristics.

**Table 4.1 Biographic characteristics of participants**

| **Biographic characteristics** | **Frequency** |
|---|---|
| **Age** | |
| 20-24 | 7 |
| 25-29 | 8 |
| 30-35 | 15 |
| | *N*=30 |
| **Level of education** | |
| Primary education | 4 |
| Secondary education | 21 |
| Tertiary education | 5 |
| | *N*=30 |
| **Ethnicity** | |
| Black | 29 |
| Coloured | 1 |
| Indian | 0 |
| | *N*=30 |
| **Marital status** | |
| Single | 23 |
| Married | 5 |
| Co-habitation | 2 |
| | *N*=30 |

| | |
|---|---|
| **Employment** | |
| Employed | 12 |
| Unemployed | 14 |
| Self-employed | 1 |
| Temporary | 3 |
| | *N*=30 |
| **Religion** | |
| Christian | 28 |
| Muslim | 1 |
| Atheist | 1 |
| | *N*=30 |
| **Number of children** | |
| 0 | 4 |
| 1-2 | 19 |
| 3-4 | 6 |
| 5-6 | 1 |
| | *N*=30 |

**Table 4.2 History of termination of pregnancy**

| **Number of previous TOPs** | **Number** |
|---|---|
| 0 | 3 |
| 1-2 | 27 |
| | *N*=30 |
| **Duration of terminated pregnancy** | |
| 1-4 weeks | 12 |
| 5-8 weeks | 11 |
| 9-12 weeks | 3 |
| 13-16 weeks | 1 |
| Unsure | 3 |
| | *N*=30 |

**Table 4.3 Mental Health before termination of pregnancy**

| **Mental health before TOP** | **Yes** | **No** | **Missing** | ***N*** |
|---|---|---|---|---|
| Faith is of great importance to me | 29 | 1 | 0 | 30 |
| I felt fit and strong | 12 | 17 | 1 | 30 |
| My life was worth living | 16 | 13 | 1 | 30 |
| I felt close to another person | 19 | 10 | 1 | 30 |
| I felt content with my life | 14 | 14 | 2 | 30 |

**Table 4.4 Personality characteristics**

| Personality characteristics | Yes | No | Missing | *N* |
|---|---|---|---|---|
| I easily forgive others | 23 | 5 | 2 | 30 |
| I think for a long time about my problems | 14 | 15 | 1 | 30 |

- **Age**

Most (50%) of participants in the sample were 30-35 years old. They are followed by 25-29 year olds who were 8 (27%) and 20-24 olds were seven (23%). All participants terminated their pregnancies during adolescence and were between the ages of 16 to 19 years, with a mean age of 17,5. The United Nations Population Fund (UNFPA) along with the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) define adolescence to be between the ages of 10-19.

According to Lowdermilk et al (2016:72), by age of 15, 13% of teens are sexually active, but by age 19, 70% of teens have been involved in sexual relations. A sexually active teen that does not use contraception has a 90% chance of falling pregnant within one year (Lowdermilk et al 2016:72).

By age 20, one third of all American girls fall pregnant. For most of these young women, pregnancy is unplanned and unwanted at conception. The pregnancy rates for teenagers in the United States are highest in the industrialised world (Lowdermilk et al 2016:72). According to Curley and Johnston (2014:305), those women at highest risk are usually younger than 25 years of age.

In South Africa, by 2006, the age specific fertility rate for the 15-19 year old women was estimated at 66 per 1000 (Makiwane & Udjo 2006 as cited in Macleod & Tracey 2010:21). The rate of teenage fertility is lower in South Africa than the overall rate in sub-Saharan Africa, but higher than most European countries. Childbirth to teenage mothers in South Africa tends to take place outside marriage as compared to other sub-Saharan African countries (Macleod & Tracey 2010:21).

Teenage pregnancy, especially among the 16 year olds and younger, may introduce additional stress into an already stressful developmental period (Lowdermilk et al 2016:72), as well as poor coping after abortion (Foster, Gould & Kimport 2011:84). The emotional level of teens is characterised by impulsiveness and self-centred behaviour and they are often prone to peer pressure. In the process of trying to establish an independent identity, many teens do not realise the consequences of their sexual behaviour. According to Lowdermilk et al (2016:72), their thinking processes exclude preparation for the future as well as perceived lack of risk, peer norms, gender power relations, fear of adult attitudes to contraceptive use, and economic context of adolescent sexuality (Ehlers 2003; MacPhail & Campbell 2001 as cited in Macleod & Tracey 2010:30).

On the contrary, younger women are less likely to speak to their partners about contraceptive use than older ones (Manzini 2001 as cited in Macleod & Tracey 2010:30).

- **Level of education**

Most participants, 21 (70%) had secondary education and 5, (17%), participants had tertiary education while those with primary education were 4 (13%) participants.

Research (Macleod 1999; Manzini 2001 & Crouch 2005 as cited in Macleod & Tracey 2010:31) indicates that many young women who became mothers actually left school before pregnancy. Reasons for leaving school before the end of Grade 12 included poverty, absence of parents at home, need to care for siblings or sick family members at home as well as other curriculum-related factors (Human Science Research Council 2007 as cited in Macleod & Tracey 2010:31). Macleod and Tracey (2010:31) assert that school engagement and school attendance are protective factors against teenage pregnancy because most teenagers fall pregnant after leaving school.

Low level of education also negatively affects the use of contraceptives (Kaufman et al 2004 as cited in Macleod & Tracey 2010:29). According to Lowdermilk et al (2016:102), poor and uneducated women tend to be overly represented in abuse probably because they are financially dependent, have fewer resources and support systems, and may

have fewer problem solving skills. The lower the level of education, the lower the financial status and therefore the higher their financial dependence.

- **Ethnicity**

In this study there were 29 Blacks and one Coloured. Blacks were over-represented because the research was conducted from a Health Centre that catered for Blacks and Indians from an Indian township. These findings resonate with Lowdermilk et al (2016:104) who found that African-American men are more likely to be psychologically, socially and economically oppressed and discriminated against. As a result, violence may occur more frequently with their partners because of anger generated by environmental stresses and limited resources.

- **Marital status**

Of the 30 participants, 25 were unmarried, five (5) were married and of the unmarried group, two (2) were in co-habitation. Budlender, Chobokoane and Simelane (2004:5 as cited in Sebola 2014:43) affirm that cohabitation is a problem, especially among poor women. The contrast in this study is that of the 25 unmarried participants, only two were in cohabitation. Hlalele (2008:10 as cited in Sebola 2014:43) detected that women desire to get married before giving birth and they therefore opt for termination of pregnancy for their unwanted pregnancies.

- **Employment**

Fourteen (14) participants were unemployed, twelve (12) were employed, three (3) were in temporary employment and one (1) was self-employed. Most employed participants were domestic workers. Of the unemployed, one (1) participant was anticipating to resume her tertiary studies. This confirms Hlalele's reflection that adolescents opt for TOP in order to continue with their education (Hlalele 2008:9 as cited in Sebola 2014:44). Those unemployed inevitably rely on their partners or family members for financial support. Teenagers usually lack the financial resources to support a pregnancy hence many opt for termination (Lowdermilk et al 2016:73).

- **Religion**

In terms of religion, most participants, 28 were Christians, one (1) was Muslim and one (1) participant cited no religious affiliation. In a study on the preferences for psychological treatment after abortion among college students who experienced psychological distress, Curley and Johnston (2014:318) reported the expressed desire by student participants for assistance with spirituality. For this age group, spirituality plays an important role in death and loss. Therefore, losing a pregnancy often provokes questions concerning values as well as meaning of life and death. This desire suggested that participants took their abortion seriously and aimed for resolving the experience. In this study, some participants may have recognised the humanity of the foetus or the transcendent nature of abortion as a death experience. This concern by participants may reflect their needs for closure, self-forgiveness, forgiveness and meaning of the abortion experience (Curley & Johnston 2014:318).

- **Number of children**

At the time of the interview, nineteen (19) participants had between one and two children while seven (7) participants had between three and four children and four (4) participants had no children. Some participants stated that they decided to terminate pregnancy because they had children and were unemployed.

### 4.3.2 History of termination of pregnancy and Mental Health before TOP

- **Number of previous TOPs**

Three (3) participants reported only one TOP and 27 participants had two terminations. The 27 participants who had two TOP's each could be accounted for the fact that most women who regret having terminated a pregnancy may compensate by falling pregnant soon after the abortion in order to make up for the aborted child. According to Rohrs (2017:39), the woman may abort this one as well to reinforce her belief that abortion is right or carry the baby to term as a substitute for the aborted baby or it could simply be that she cannot afford another child.

- **Duration of terminated pregnancy**

Twelve (41%) participants were 1-4 weeks pregnant, 11 (37%) participants were 5-8 weeks pregnant and 3 (11%) participants were 9-12 weeks pregnant while 3 (11%) were unsure. In a seminar report paper on abortion decision-making in South Africa (IUSSP Scientific Panel on Abortion Research, Lagos 2014: 2), it was noted that the main contributors to the delay to terminate were the time of recognising a pregnancy, duration of decision-making to abort, reaching a health facility and receiving qualitative care. Other factors delaying getting an abortion were being a teenager, seeking care somewhere else first or not knowing where to go for TOP.

- **Mental health before termination of pregnancy**

Twenty-nine (97%) of participants asserted that faith was of great importance to them. This tallied with the finding that 28 of participants in the present study were Christians and one was a Muslim. According to the International Seminar on decision-making regarding abortion report paper (IUSSP Scientific panel on Abortion Research, Lagos 2014:5), religious factors have a strong influence on abortion behaviour and abortion decision. Twelve (12) of the participants indicated that before terminating pregnancy, they felt fit and strong, while seventeen (17) did not feel fit. Sixteen (16) felt that their lives were worth living and thirteen (13) felt that their lives were not worth living. Nineteen participants (19), felt close to another person for support. Of the 30 participants, fourteen (14) expressed that they felt content with their lives before terminating their pregnancies while fourteen (14) were not content with their lives.

- **Personality characteristics**

“I easily forgive others” was stated by 23 (77%) participants while 5 (17%) indicated that they do not easily forgive others. “I think for a long time about problems” was stated by 14 (47%) participants while 15 (50%) specified that they easily solve problems and stop thinking about them. People with trait forgiveness have a general disposition to forgive and such people with a high trait to forgive should be more likely to also self-forgive (Terzino 2010:13).

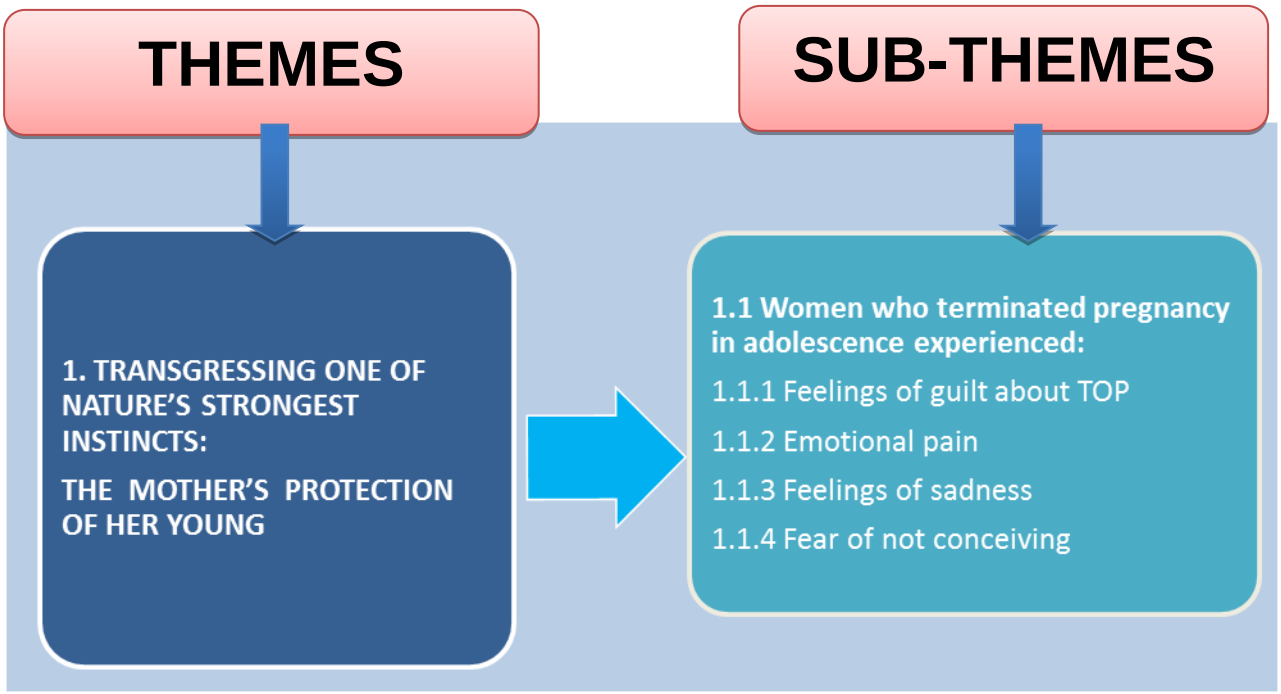
On the contrary, rumination about an offence makes it difficult for an individual to forgive the transgressor and to self-forgive. In a cross-cultural study on forgiveness and rumination, Suchday, Friedberg and Almeida (2006:86) noted that forgiveness was negatively correlated with rumination and stress.

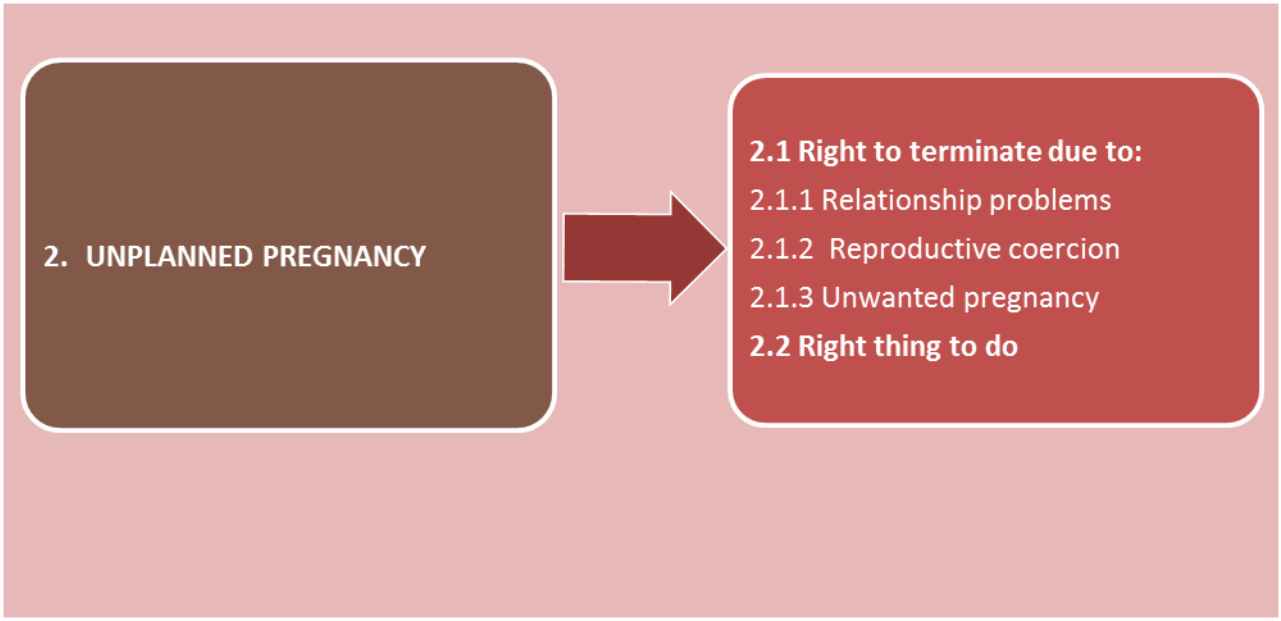
### 4.3.3 Themes and sub-themes

Five main themes and eight sub-themes emerged from the transcribed texts. The findings were based on the experiences of participants as shared in their own voices.
The following central theme, themes and sub-themes were derived from the analysed data:

**Central theme**: Women who terminated pregnancy in adolescence find a way towards forgiveness through forgiving self by having a relationship with God and prayer:

Figure 4.1 is a summary of the main themes and sub-themes that emerged.




2. UNPLANNED PREGNANCY
2.1 Right to terminate due to:
2.1.1 Relationship problems
2.1.2 Reproductive coercion
2.1.3 Unwanted pregnancy
2.2 Right thing to do


3. INTRA AND INTERPERSONAL RELATIONSHIPS
3.1 Intrapersonal
3.1.1 Relationship with self (negative aspects)
3.1.1.1Viewed self as a "murderer" (killed an innocent child)
3.1.1.2 View self as having committed a sin
3.1.1.3 Experience not having forgiven self
3.1.2 Relationship with self (positive aspect)
3.1.2.1 Experience self-forgiveness
3.1.3 Relationship with God
3.2 Interpersonal
3.2.1 Relationship with partner
3.2.2 Relationship with family
3.2.3 Relationship with community
3.2.3.1 Fear of being ostracised
3.2.3.2 Relationship with church

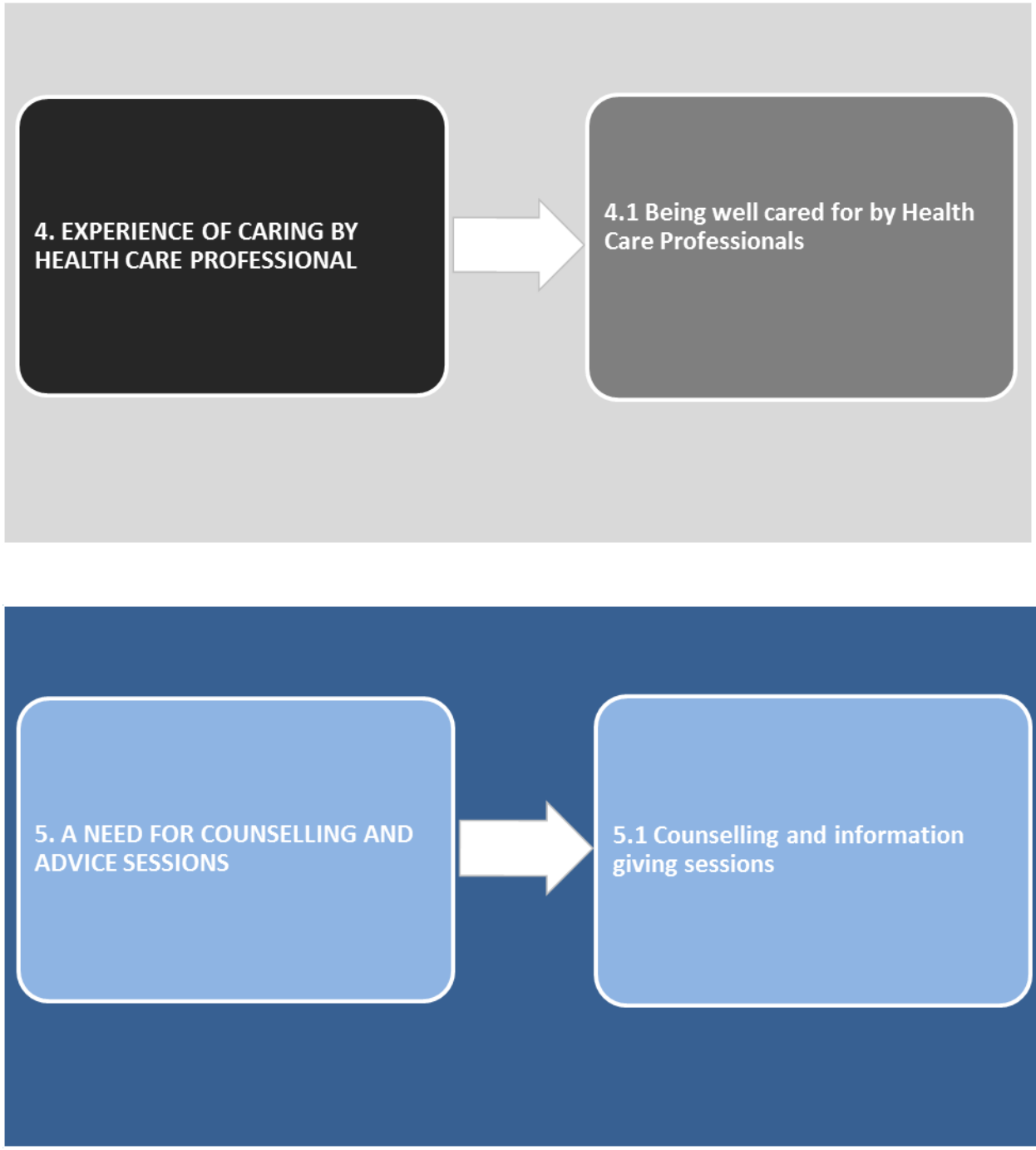
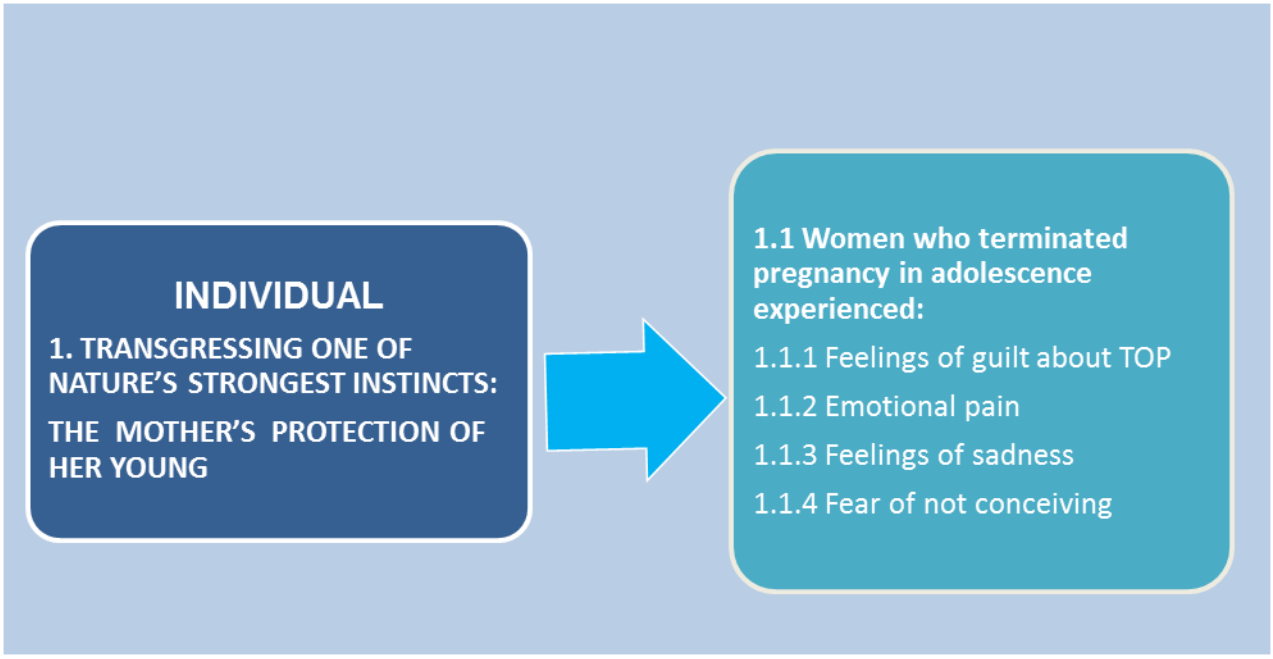



**Figure 4.1 Themes and sub-themes**

### 4.3.4 Themes, sub-themes and story lines

The Social Ecological Model levels (Figure 1.1) were superimposed on the themes of the study, in order to foster a clear visualisation of points at which health professionals can intervene.

#### *4.3.4.1 Theme 1: Transgressing one of nature's strongest instincts: The mother's protection of her young*




**Sub-theme 1.1.1: Feelings of guilt about TOP**

Regret, alone, blame myself, can't forget, bad, mistake, "it's done it's done", hurts, not right, murder and sin were the most frequent terms used to describe the experience of guilt after TOP. According to Rohrs (2017:40), guilt is a normal reaction that usually surfaces after a woman recognises that abortion is morally wrong and that she is responsible for committing her own abortion. Feelings of guilt usually follow violation of moral codes. The moral code of protecting their pre-born babies, in the case of abortion, has been violated and this causes relentless guilt.

In the present study, all participants reported that they felt guilty about the pregnancy that was terminated. Initially, most participants argued that they had no choice but to terminate, stating reasons like poverty, unemployment, cheating partner, fear of parents, having another baby or being in a relationship with a married man and therefore not wanting to destroy another woman's marriage. In the same vein, some expressed sadness and guilt because they killed innocent children instead of protecting them. It appeared the context in which they decided to terminate pregnancies changed after TOP. The following feelings were expressed:

> "I was upset about my boyfriend but thereafter I regretted it…I regret TOP…" (P2)

> "So I decided to get an abortion, but I feel guilty even now…" (P15)

> "…I must be honest, it does not settle with me very well because that's an innocent child" (P18)

Some participants expressed a fear of God, because according to their religious understanding, TOP is sin, especially in the religion of Christianity and Islam. In a study on the preferences for psychological treatment after abortion among college students who experienced psychological distress, Curley and Johnston (2014:318) reported the expressed desire by student participants for assistance with spirituality. For this age group, spirituality plays an important role in death and loss and also in losing a pregnancy.

In a study on attitudes and decision-making among 4,926 women seeking abortions at one US. clinic, 36% indicated having spiritual concerns about abortion. Conversely, 28% indicated that they were not spiritually at peace with their decision to abort. About 18% of the women reported being afraid that God would not forgive them for terminating their pregnancies. Perception of abortion as killing differed according to gestational age, with 15% of first trimester pregnancies and 26% of second trimester pregnancies (Foster, Gould, Taylor & Weitz 2012:117).

In this regard, one participant in the present study expressed the following:

> "I feel I made mistakes, guilty…I don't know whether God has forgiven me…" (P6)

Another participant put it in a different perspective:

> "I felt guilty by the time I went to church. One day a prophet told me about it. Then I could not deny. That's when I felt guilty. I feel everyone at church could see I have done abortion. It makes me feel guilty…as long as God has allowed it; maybe it's fine" (P 24).

Loke and Lam (2014:1) argue that when facing an unexpected pregnancy, teenage girls experience fear and confusion - the fear of being stigmatised and having to reveal the pregnancy to other people. Decisional conflict about TOP can lead to guilt. One participant sounded confused as she stated:

> "…that is why I feel guilty. Even though I did it, it does not mean I have accepted my decision." (P10)

Another participant added:

> "I felt better to abort than dump the child somewhere. I did not want to hate the child because when I see the child I would think of what he (partner) did to me because the child would remind me of him." (P2)

With tears in her eyes she later continued*:*

> "I felt I was doing a good thing when I did TOP…thereafter I regretted it because that child was mine, I was doing the baby for myself. I regret when I think about the baby. I shouldn't have aborted the baby." (P2)

For some participants, it appeared self-blame and self-condemnation arising from shame and guilt played havoc on them. They felt that unhappy events that have occurred to them since after TOP were "deserved" because they "killed innocent babies". One participant shared:

> "…I used to be very close to God, go to church every Sunday, and after TOP I don't think I went to church for a while-I would feel guilty and always when something went wrong in my life I would think maybe it's God who is punishing me for the abortion and staff, but…ja…" (P13).

Ely, Flaherty and Cuddeback (2010:269), in their study on the relationship between depression and other psychosocial problems, posit that depression was significantly associated with guilt, amongst others. Guilt feelings could be a signal of depression for these women.

In terms of feeling guilty, religion can be used to both get in and get out of guilt feeling. On the contrary, religion has been cited as a stressor (Hlalele 2008 as cited in Sebola 2014:51). Thoughts of having sinned against God have been cited by several participants as a cause for feeling guilty about TOP. Furthermore, several women in this study stated that they would not inform other church members regarding their terminations because they would be stigmatised. On the contrary, religion can also have a positive effect on self-forgiveness. Several participants stated that knowing that God has forgiven them has allowed them to forgive themselves and move on with their lives.

**Sub-theme 1.1.2: Emotional pain**

Being a mother and taking away the life of your own child was expressed by all participants as an emotionally painful, an uneasy experience, and a "huge" thing. One participant, taking a deep breath, voice quivering, said:

> "I feel emotional pain. Right now it hurts me…TOP has hurt me emotionally" (P23).

All participants expressed that TOP involved killing and most women admitted to themselves as being murderers of their own blameless babies. The fact that the babies were innocent tended to intensify the emotional pain. All participants who expressed this feeling said it with lowered voices, some could not look the researcher in the face and they paused in between words. The following transcribed story lines support this finding:

> "Taking out an innocent…blameless child is painful thing…" (P5)

> "It is emotionally a painful experience…I asked myself why would I do such a thing?"(P6)

> "Eish! It was emotionally painful, even right now … It never felt right inside me." (P31)

> "I feel I am a parent who did something bad to my own child. I feel emotional pain. It stresses me and right now it hurts me." (P23)

In the face of emotional pain that proved a threat to their mental integrity, some participants expressed that they voluntarily blocked from their awareness unpleasant feelings and experiences about TOP. Some revealed suppressed thoughts as follows:

> "…I don't like remembering that part of my life, because it was very painful…" (P8)

> "…Is better to forget because I was stressing a lot…I am stressed always; I didn't like to talk with others." (P29)

Personal disappointment, for which unplanned pregnancy and subsequent TOP would typically qualify, have also been associated with higher risk for major depression (Ely et al 2010:271).

The emotional pain was accompanied by sadness about the loss. One of nature's strongest instincts is for a mother to protect her young. Undergoing TOP would therefore be opposed to the mother's basic maternal instinct. This finding resonates with the finding by Makutoane (2016:38), that following an abortion, women often have feelings of betrayal towards their unborn babies. Although the participants had valid reasons for undergoing TOP, their maternal instincts to protect their young were violated, and subsequently feelings of emotional pain followed. These findings resonate with the findings of Van der Walt (2015:28), that following an abortion, women often struggle emotionally.

**Sub-theme 1.1.3: Feelings of sadness**

All participants expressed sadness around deciding to do away with the lives of their babies. In addition, the way the products of conception were disposed of caused sad memories for some, as stated by one participant who saw her formed foetus before its disposal:

> "I wish we could at least say goodbye properly or maybe to the baby…or at least that the baby can be recognised…that there was such a person…that is my wish. I think it would help me heal…get buried in dignity. The way we disposed of the baby…(pause)…ja… we didn't do it right…I think it would help me heal. " (P13)

According to Sebola (2014:51), some mothers who aborted still feel sad whenever they see other mothers struggling with their children.

> "I was not feeling well, not feeling happy…because I killed a baby who would do things, I would send around (voice low), and he would serve God, but I decided to abort him - I am always asking myself all those questions." (P31)

The guilt of having destroyed a life was accompanied by sadness and crying.

**Sub-theme 1.1.4: Fear of not conceiving in the future**

Some participants worried about their inability to conceive after TOP. This is usually explained to them by the TOP clinic manager as one of the possible complications after TOP. This fear is often escalated by the guilt of having sinned, and they may feel it is one of the punishments they deserve.

> "The risk that I may not be able to conceive a child worries me. I still think, will I have a child in the future ?" (P2)

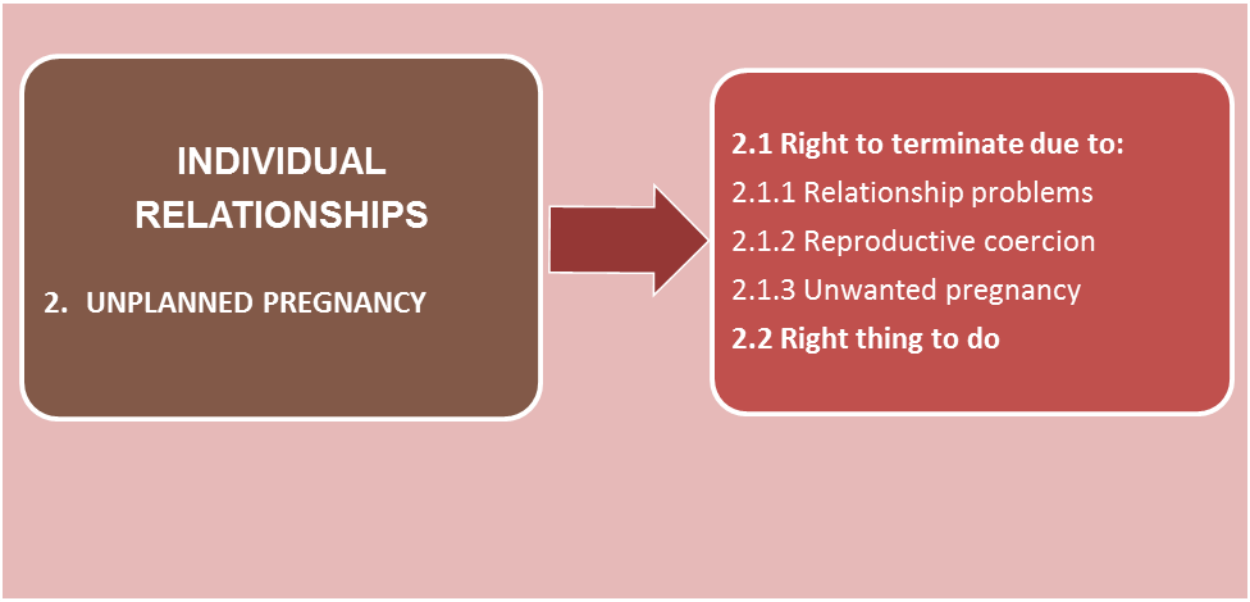
> "My womb, what if it does not conceive…I think a lot, especially about around that the time when I will need another 2nd child." (P6)

> "…I was worried what if something had gone wrong with TOP, what if I can't have other babies…" (P8)

It was expressed as follows:

> "I was scared for the future, asking myself: 'am I ever going to have other kids or what?'…" (P24)

#### *4.3.4.2 Theme 2: Unplanned pregnancy*




**Sub-theme 2.1: Right to terminate**

Participants expressed the right to terminate because of relationship problems, reproductive coercion and unwanted pregnancy.

**Sub-theme 2.1.1: Relationship problems**

During adolescence, the teenager seeks to build a positive self-image. If the interaction between the teenager and the partner is positive, the adolescent will develop a positive self-image. Adolescents who have to prove their worth, for example by using their bodies for sex, may fall pregnant in order to please the partner, endure continuous ridicule or experience an identity crisis. They may seek attention outside the home (Bezuidenhout 2017:75).

For some women the relationship was initially good:

> "Me and my partner agreed to have a child. I was afraid that if I refused he won't buy me gifts." (P2)

After falling pregnant, things started changing:

> "…he would answer my phone, he would read my messages for me, if I spoke to any man without asking him, he would hit me…" (P2)

> "He was cheating."(P14)

> "…when I became pregnant…he was starting to be abusive, he started hitting me and being violent…for any mistake he would hit me…" (P1)

> "…I fell pregnant. He started being aggressive, telling me he no longer loves me, and that I had to move out of his house. I was surprised because he knew I was pregnant…I was feeling hopeless. So I decided to terminate." (P31)

> "…when I became pregnant he changed completely for the worst." (P33)

> "He used to beat me. He was an alcoholic, he used to beat me and the children…" (P10)

Therefore, these participants had no choice but to terminate:

> "I had conflict with my partner. So I terminated the pregnancy because of my problems with my partner." (P11)

> "…so I decided to terminate." (P31)

**Sub-theme 2.1.2: Reproductive coercion**

Male partner RC is explained as male partner attempts to promote pregnancy in their female partners through verbal pressure, threats, and coercion related to pregnancy continuation or termination. These mechanisms were evident in the present study:

> "He started being angry,…he forced me into sex relationship…I fell pregnant." (P6)

> "…he would answer my phone, he would read my messages for me, if I spoke to any man without asking him, he would hit me…" (P2)

> "I felt it would disappoint my parents. So I think I did it for myself (dragging her voice), also, in part I was pressured as well." (P13)

Some women were deserted by their partners and that compelled them to decide on TOP in order to rectify all that had gone wrong. As indicated by one participant:

> "Even if he didn't force me, but whenever you go to someone, things happen…(slowly, with a low voice) the regrets and everything stay with you…because that time I had to make a decision to say "I'm aborting this thing, I am alone." (P24)

According to Miller and Silverman (2010:511), unintended pregnancies are two to three times more likely associated with intimate partner violence (IPV) than planned pregnancies. Once the female partner is pregnant, an abusive male partner may control the outcome of the pregnancy by including violent acts and coercion to either continue or terminate the pregnancy (Miller & Silverman 2010:511). Some women in this study, in the face of RC, were forced or they decided to terminate their pregnancies.

> "…so my boyfriend told me to do abortion. I did not want to terminate." (P23)

> "…so abortion wasn't really an option. If he had not talked about abortion I would not have done it. I did not tell him I did not want to abort. I just asked him what would happen if I did not abort. So he was angry, and he said he would find out. After that, he kept quiet. Never answered that." (P13)

World Health Organization (2012) listed interpersonal violence as the fifth leading cause of death among adolescents. It is more prevalent within communities in the low socio-economic settings.

**Sub-theme 2.1.3: Unwanted pregnancy**

Unintended pregnancy is broadly defined as unplanned, unexpected or mistimed pregnancy, or not wanted by a woman, is common and unduly affects younger women

(Miller & Silverman 2010:511). However, unwanted is not the same as unintended. Macleod and Tracey (2010:21), in their study on a follow-up review of South African research on the consequences of and contributory factors in teen-aged pregnancy, reported that 42,6% of the pregnancies among teenagers were unintended but not unwanted. A reliable indicator of an unwanted pregnancy is TOP. More young teenaged women have unwanted pregnancies than do older women (Macleod & Tracey 2010:21). The reasons stated for unwanted pregnancy varied. Most women felt they would not afford another child because they were not married and were unemployed, some already had other children and a few others were in abusive relationships. Therefore, the pregnancy was unwanted or unplanned. Participants stated the following:

> "…we have various reasons why we want to terminate. It was an unwanted pregnancy…" (P20)

> "…but because I got pregnant unprepared I decided…I have a nagging feeling it came at a time I did not plan…" (P1)

**Sub-theme 2.2: Right thing to do**

Some women felt that they did not want to be single mothers, or they needed to improve their lives so they terminated pregnancy for their own good, as supported by the following statements:

> "I also want to upgrade my education. I wanted to terminate it, this is my life." (P17)

> **"**So I had to make a decision if I am going to keep it or terminate it and I was not ready to be a single mother." (P6)

Other participants were left alone as soon as their partners learnt of the pregnancy, and these women found it right to terminate their pregnancies for the good of the other children and the unborn baby. Some expressed the following sentiments:

> "…so I fell pregnant. He started being aggressive, telling me he no longer loves me…and that I had to move out of his house." (P30)

‘’I did not know this man properly. He was cheating…Yes, you need to stay with the boyfriend for some time before you decide on pregnancy.” (P14)

“What caused me is because my boyfriend is not working, and I have a small child…” (P27)

“I am having two children with him…and am struggling with those two children”. (P30).

Women who felt it was the right thing to do had definite reasons for terminating and they had no regrets:

“It’s a good decision because sometimes you can have a baby without a plan…” (P32)

“The child was innocent. I had no choice but to do it…” (P4)

“…I did it because of some reasons, otherwise I would not have terminated it” (P5)

“…even now I don’t have regrets that I terminated the pregnancy because I was not ready to have a child” (P20)

#### *4.3.4.3 Theme 3: Intra and interpersonal relationships*


**Sub-theme 3.1: Intrapersonal relationships**

Participants expressed some issues within themselves. Some of the expressions were related to the negative aspects of self and some were the expression of positive views about self.

### Sub-theme 3.1.1: Relationship with self (negative aspects)

Three aspects emerged from the subtheme of negative relationship with self.

#### Sub-theme 3.1.1.1: Viewed self as a "murderer" (killed an innocent child)

There were negative aspects to relationship with self, where some participants viewed themselves as murderers who killed their innocent babies in utero. This caused a negative emotion of shame, sadness and regret about TOP.

Shame involves an excessive and critical focus on the self, rather than on the offensive behaviour, (as in guilt), and it is more likely to promote the self-destructive intentions associated with lack of self-forgiveness. According to Tangney (1991 as cited in Rangganadhan & Todorov 2010:5), shame proneness is associated with a tendency to externalise cause or blame and to anger, provocation and hostility, in this case, hostility to self. These emotional factors will likely limit the shame-prone women's efforts to deal effectively with their offence of "murder" and its consequences of feeling guilty and ashamed. Hall and Fincham's model of self-forgiveness proposes a negative association between shame and self-forgiveness, meaning that women who regard themselves as murderers will find it difficult to forgive themselves for having done TOP. In their research on personality and self-forgiveness, Rangganadhan and Todorov (2010:10) reveal that religiosity was not a significant factor in self-forgiveness. In the same study, women were found to score significantly higher than men on t-tests measures of shame, guilt and personal distress. This implied that women who terminated pregnancy will find it difficult to self-forgive. Some participants in the present study did not only state that they committed murder but that they are murderers, as confirmed by the following story lines:

> "…it means I committed sin…I am murderer. I killed innocent blood." (P6)

> "You know to terminate pregnancy, it makes me feel like I am a killer. I have killed someone…" (P18)

According to Mills (1995:405), the sin of murder reveals a person's moral failure, which betrays one's self-image as a moral being. Committing murder harms the self because one has acted against one's moral code of protecting one's unborn or innocent baby. In the present study, this experience led to guilt and shame. Guilt and shame in turn may lead to negative emotions like depression, anxiety, suicide ideation, among others. The following statements were expressed with sadness and sometimes with tears:

> "The child was innocent…TOP is like killing…" (P4)

> "It's a human being and I killed it…I denied it the chance of coming into this world" (P8)

> "…So when you abort you are killing…" (P11)

> "It's like killing your own child…because already everything is formed…" (P13)

> "We kill innocent blood…children who know nothing…" (P5)

Shame has been strongly linked to psychopathology and high levels of this emotion would be expected to complicate the difficulties associated with a lack of self-forgiveness (Rangganadhan & Todorov 2010:1). Shame-prone persons evaluate their entire self negatively, instead of their acts. In real life, it is important to keep in mind that people may endorse varying levels of both shame-proneness and guilt proneness. There is a strong correlation between these two emotions.

To resolve shame, Fisher and Exline (2010:552) emphasise the development of empathy, personal responsibility and a sense of control, while working to reduce the offender's shame-based identity as a bad person. Women who regard themselves as murderers need to be taught to differentiate between themselves and their action of TOP, learning to accept that doing bad things does not necessarily mark them as bad people (Braithwaite 2000 as cited in Fisher & Exline 2010:552). Working towards reparative behaviours and prosocial identities will help these women to transcend their identity as murderers.

Tangney and Stuewig (2004 as cited in Fisher and Exline 2010:552), suggested that educating people about the difference between shame and guilt as well as between bad

behaviour and being a bad person may help to reduce shame while also offering the hope of being a good person and the possibility of positive change. This will help reduce less punishing attitudes.

To cope with shame, it may also be necessary to work towards a sense of humility, self-compassion and self-acceptance. According to Exline, Campbell, Baumeister, Joiner, Krueger and Kachorek (2004 as cited in Fisher and Exline 2010:552), humility implies non-defensive willingness to see the self accurately, including both strengths and limitations. On the contrary, self-compassion implies the ability to extend kindness and understanding toward the self instead of judgement, recognition that human flaws are part of the greater human experience and the capacity to practice mindfulness regarding painful feelings instead of over identifying with them. Cultivating a humble or self-compassionate stance should enable people to tolerate looking at their weaknesses without lapsing into shame.

According to Rowe and Halling (1998 as cited in Fisher & Exline 2010:552), as women work towards self-forgiveness they need to:

- Come to a point of self-acceptance.
- Be aware that flaws are an inherent part of human nature.
- Feel connectedness to all human experience themselves in a hopeful light.
- Continue acknowledging negative feelings while being able to prevent those feelings from permeating every aspect of their lives.
- Retain their sense of responsibility for wrong-doing.
- Reduce shame so that they can face their personal limitations while still seeing their positive side.
- Realise that negative emotion is necessary to fuel repentance.

The risk associated with high shame-proneness and low guilt-proneness supports intervention efforts that aim to not only reduce shame-prone responses but to also enhance more guilt-prone responses. Cognitive, action-oriented interventions may help to reduce the tendency for a woman to negatively evaluate her entire self as a murderer. Reorganising the thought processes of a woman who regards herself as a murderer, reparative responses to women's shame-oriented statements about

themselves would reduce shame-proneness and improve the protective effect of guilt-proneness (VanDerhei et al 2014:328).

**Sub-theme 3.1.1.2: View self as having committed a sin**

In the present study, all participants expressed guilt of the sin of murder. Most participants accepted responsibility for the sin of murder, without condemning their entire selves. The guilt of having committed the sin of TOP is echoed in the following statements made by participants:

> "…I have done a sin…it means that I have done wrong in God's eyes." (P9)

> "…I made a sin here on earth…God knows that what I have done is sinful." (P14)

> One participant who confessed to be an atheist, stated that although she had no relationship with God or a Higher Being, yet she felt bad because she killed innocent blood. The rest of the participants expressed that faith in God was important to them and they therefore experienced remorse and guilt for their sin. They believed that God will punish them for their sin and that they needed to pray and ask for God's forgiveness. As they believed in life after death, a few expressed that if God forgave them, they would meet their babies in heaven and this gave them hope.

> "I need God in my life. God has forgiven me. " (P7)

> "It's same as you made a sin in the eyes of God… you feel you committed sin but everyone deal with it her own way." (P3)

> "You can't have pregnancy tomorrow and say that you are going to terminate. It is to kill; it's a sin." (P16)

The above statements express remorse, a willingness to humble the self and to repent of one's misdeed. It is important to do away with shame as it focuses on the transgressor and not on the wrong act. Remorse by itself expresses guilt, sorrow and regret, which are important emotions for self-forgiveness.

When resolving guilt, attempts to make reparations towards the self may be effective. As cited by Fisher and Exline (2010:553), Tangney and Dearing (2002) found that the main difference between positive and negative experiences of guilt lies in whether a person makes reparations with self or changed behaviour so as to not transgress again. In an ideal situation, remorse will prompt reparative measures, and will eventually help reduce guilt (Fisher & Exline 2010 553).

As cited by Fisher and Exline (2010:141), Holmagren (1998) argues that feelings of guilt will disappear when people have learned from their mistakes and have made sincere attempts for reparations with self. Although self-forgiveness may help reduce guilty feelings, some transgressors may feel that it is not enough. The damage cannot be reversed, such as in TOP, where the unborn baby is no more. In such situations, high levels of guilt and remorse can backfire and become oppressive (Fisher & Exline 2010:554). Self-punishment may be an avenue some transgressors turn to when they feel that their reparative attempts are not adequate. However, self-punishment might have a negative effect of deepening shame because it only focuses on the transgression while ignoring the solution of repentance and growth. As cited by Fisher and Exline (2010:554), Holmgren (1998), further states that with self-punishment, as long as the individual feels that self-forgiveness is insufficient, the punishment will be perpetuated. In contrast, acts confession about the sin of TOP can be implemented by these women after which they should start experiencing relief from guilt, leading to the transgressor focusing more on reparations than on the transgression.

**Sub-theme 3.1.1.3 Experience of not having forgiven self**

Some women expressed that they did not know about self-forgiveness, meaning that they needed to be taught about it. Some participants said*:*

> "I don't know about forgiving myself." (P23)

> "…I haven't forgiven myself…I don't know about self-forgiveness." (P5)

According to Peterson et al (2016:160), the failure to forgive self may stem from lack of knowledge about self-forgiveness. There is a need to teach women about self-forgiveness.

Participants who struggled with lack of self-forgiveness complained that they meditated repeatedly about the experience of TOP:

> "I never had time to forgive myself…I haven't forgiven myself…" (P2)

> "I can't forget about my TOP. When I am alone, I think of that TOP…I tried to write these thoughts on my laptop so that I forget but it makes no difference." (P2)

> "I don't think I will totally forgive myself, just like I will never forget the baby." (P13)

Although they had not yet forgiven themselves, other participants had hope that with time, they will come to forget about the experience. They stated:

> "It will take time to go to the position where I was before abortion." (P17)

> "…I am still asking forgiveness because I don't know it, I will be accepted…" (P9)

Other participants who experienced shame found it difficult to forgive themselves. According to Fisher and Exline (2010:551), individuals with shame-prone nature have characteristics that seem to impede self-forgiveness, for example, directing negative emotion at the whole self instead of focusing on the wrong committed. Therefore, shame makes self-forgiveness more difficult.

The next story line reveals this:

> "…by the way, I am a murderer…" (P6)

> "I don't see myself being the person I was. I am a murderer." (P27)

The above story lines indicate that these participants see their whole selves as murderers. This negative identity can cause them to feel powerless, small, or defensive, with a sense of being exposed and wanting to hide (Fisher & Exline 2010:551).

### Sub-theme 3.1.2: Relationship with self (positive aspect)

#### Sub-theme 3.1.2.1: Experience self-forgiveness

Some participants expressed that they had forgiven themselves and were feeling good about it. According to Wohl and Thompson (2011:354), the ability to forgive the self for engaging in an offense has always been viewed as beneficial to the individual's psychological as well as physiological well-being. The authors further indicate that self-forgiveness for behaviours that are in the past, for example TOP, might be beneficial in that it reduces self-blame and restores self-esteem (Wohl & Thompson 2011:362).

In granting self-forgiveness for TOP, the woman must accept responsibility for terminating the pregnancy and the consequences thereof. This will help to dispel negative emotions directed at self.

> "…I always pray to ask Him to forgive me…I confessed my sin of TOP because with God there are no secrets." (P6)

> "I have to ask for forgiveness from God when praying. I believe God answered my prayers on forgiveness for my termination…" (P3)

According to Peterson, Tongeren, Womack and Hook (2017:159), self-forgiveness can alleviate feelings of self-punishment and condemnation but only when offenders take responsibility for their action. Other participants had already forgiven themselves:

> "I have a conscience that does not feel guilty. So I have to forgive myself that I have done this…I had to forgive myself before someone else could forgive me." (P1)

> "I have forgiven myself. I don't think about it anymore…I have accepted it happened, it's gone…" (P3)

> "…I chose to forgive myself…" (P7)

> "…I first asked for God's forgiveness. Then after that I forgave myself." (P10)

> "People who can't forgive themselves should go for counselling. I think they will have to be reminded of the main reason they did that (TOP) so they understand and accept it."(P33)

Self-forgiveness is related to psychological well-being, life satisfaction, meaning, and general quality of mental health (Peterson et al 2017:160), although its experience does not necessarily mean that all negative feelings are eliminated. Therefore, people who forgive themselves may also continue to carry negative feelings such as remorse, disappointment and regret (Fisher & Exline 2006:141), depending on the severity of the offence.

In contrast to remorse, self-condemnation is a more holistic, negative and severe opinion of oneself. Remorse includes sorrow towards a transgression whereas self-condemnation is about self-hatred and a desire for self-punishment. Therefore, in order to move towards self-forgiveness, self-condemnation must be avoided, while maintaining remorse and regret (Fisher & Exline 2006:141).

While people should not condemn themselves, it is important for them to take responsibility for their transgressions. Those who accept responsibility for their transgressions are more likely to move towards self-forgiveness. However, as cited by Fisher and Exline (2010), Hall and Fincham (2005) suggest that for self-forgiveness to be effective and genuine, the process of accepting responsibility should take time and should not be rushed to get rid of guilt feelings. For women who terminated pregnancies, it is important that they accept responsibility for their transgressions so that they experience genuine self-forgiveness.

Women who have low self-esteem and who are prone to shame will more likely condemn themselves after TOP. It is critical that they are taught to reduce feelings of self-condemnation in order to promote self-forgiveness. As cited by Fisher and Exline (2006:142), and Exline et al (2004) suggest that self-condemners should be provided with a safe interpersonal environment where their value and self-esteem are affirmed. When people feel safe, they can be gently directed in the way of remorse, repentance and humility, and away from self-condemnation and self-punishment.

A contrasting problem exists where egotistic individuals are involved. Such people feel entitled and are narcissistic and not humble. As cited by Fisher and Exline (2006:142), Tagney and Dearing (2002) underscore that they are less likely to accept responsibility for their transgressions. As a result, they seek a quick and easy fix to their negative feelings, where they will likely justify their transgressions and seek to blame. Fisher and Exline (2006) suggest that to fix this behaviour, they should be provided with a safe interpersonal environment so that they accept responsibility without falling into shame and self-condemnation.

**Subtheme 3.1.3: Relationship with God**

Twenty-nine (29) participants who belonged to Christianity indicated that through prayer, they would ask God for forgiveness for their sin of killing their unborn babies. Some of these participants already believed that God had already forgiven them. Others believed that after God has forgiven them they would be able to forgive themselves.

They believed that they could not hide anything about the TOP from God.

> "I have to ask for forgiveness from God when praying. I believe God answered my prayers on forgiveness for my termination…" (P3)

> "…I always pray to ask Him to forgive me…I confessed my sin of TOP because with God there are no secrets" (P6)

> "I must ask forgiveness from God. In our church there is somebody to whom I can report what I have done…I have to ask forgiveness from Him." (P2)

> "I need God in my life. God has forgiven me." (P7)

> "…I feel that God has forgiven me…" (P10)

> "I just ask God to forgive me…" (P16)

> "Because there is no secret you can hold against God….I have to ask for forgiveness" (P1)

- **Prayer as a way towards forgiveness**

In a study on the preferences for psychological treatment after abortion among college students who experienced psychological distress, Curley and Johnston (2014:318) reported the expressed desire by student participants for assistance with spirituality. For this age group, spirituality plays an important role in death and loss and also in losing a pregnancy through abortion.

The reason for spirituality was summarised as follows:

> "Abortion is a huge thing. There is nothing as huge as abortion. People do things but abortion is too huge because you are killing an innocent baby who needs to be alive like you." (P27)

In the present study, 29 of the 30 participants reported that they prayed and would continue praying to God for forgiveness of their sin of killing. They prayed because they felt guilty. For many, it was important to confess the sin of TOP in order to receive God's forgiveness and to subsequently forgive themselves.

> What is done is done. What is needed is that I must be strong, attend church…for God to forgive me." (P4)

> "I prayed about my guilt. I confessed my sin of terminating pregnancy…" (P6)

> "I was encouraged by the Bible…I forgot it. God said we must not kill…so I had to go on my knees and ask for forgiveness." (P9)

> "…I can't live without. I am in prayer all the time. Anything I do and say I pray about it." (10)

Attending church was important to participants although some revealed that their church excommunicated them from attendance for three to six months. The reason for this was that church elders believed they made the church dirty because they killed unborn babies. One participant argued that she even prayed to God for strength during the procedure of TOP. A few others stated that they prayed at home for a safe procedure before leaving for the hospital to undergo TOP.

The following story lines support this:

> "Pray, I pray to God…during procedure I told God I am killing a person, forgive me. Hold my hand God, through this procedure." (P7)

> "I came to the clinic for TOP crying. Will I live or die? I prayed the night before TOP because I actually did not like undergoing TOP." (P12)

The above statements indicate that women who terminated pregnancy understand TOP to being a spiritual experience, where they communicated with God through prayer. Confession of the sin of abortion to the church elders and to God in prayer was important so that nothing remained hidden to God. Being forgiven by God was also important so that they can forgive themselves and be free of guilt and shame.

**Subtheme 3.2: Interpersonal relationships**

Relationships with others also emerged as a sub-theme for the study.

**Subtheme 3.2.1: Relationship with partner**

Of the 30 participants, 25 (80%) were unmarried, 5 (13%) were married and of the unmarried group, 2 (7%) were in co-habitation. Most participants stopped the relationships either after pregnancy or after TOP.

Reasons given for break up were as follows:

- **Infidelity**

> "He loved girls, no financial support, we parted after termination." (P3)

- **Just disappearing after learning of pregnancy:**

> "We parted…he went away, I left him to go, I did not follow him…" (P5)

"…even now we don't talk…" (P9)

- **Conflict, intimate partner abuse (IPV)**

The following statements from participants attest to some form of IPV:

> "We are fighting. When I checked my messages on my phone, he told that it is over because I terminated…" (P32)

> "I did not tell him when I fell pregnant because he was abusive…hitting me, being violent, answer my phone, read my messages, not allowed to speak to other men. So I decided alone to terminate. We broke the relationship after abortion." (P2)

> "…so I fell pregnant. He started being aggressive, telling me he no longer loves me, and that I had to move out of his house." (P31)

The likelihood of IPV increases during pregnancy. According to Lowdermilk et al (2016:102), poor and uneducated women tend to be disproportionately represented in abuse because they are financially dependent, have fewer resources and support systems, and may have fewer problem solving skills. In the present study, the majority of participants, that is, 70%, had secondary education as the highest level and 17%, that is 5, had tertiary education. The rest, that is, 4 which is 13% had primary education as the highest level of education.

Women generally value their social roles and this may have an influence in IPV. Traditional feminine characteristics such as compassion, sympathy and yielding often result in greater tolerance of male dominance and more acceptance of partner violence.

In contrast, the qualities of assertiveness, independence and willingness to take a stand have been viewed as characteristic in women who are in nonviolent relationships (Faramarzi, Esmailzadeh, & Mosavi 2005 as cited in Lowdermilk et al (2016:102).

Believing that being pregnant protects a woman from IPV is a myth as 4% to 8% of all women who experience violence experience it during pregnancy (Lowdermilk et al 2016:103). It is also reported more frequently in lower-class families although it can be

reported in any family. Of the 30 participants, 25 (80%) were unmarried and the five that were married stay with their husbands.

**Sub-theme 3.2.2: Relationship with family**

Some participants were in good relationship with family although they kept the TOP a secret, for fear of disappointing parents or other family members by falling pregnant. It would appear that TOP was done to hide the pregnancy, as well as the sexual activities.

Some participants reveaed the following:

> I'm very close with my mom. But I decided that I am not going to share this with my mom…" (P20)

> "I disappointed them through falling pregnant." (P7)

The pregnancy was mostly revealed first to the partner and thereafter to the mother or to the most trusted family member.

> "…then I fell pregnant, I told him that I was going to do abortion. He agreed because he is married." (P4)

> "… I told him I am pregnant." (P9)

The TOP was either revealed to the most trusted family member, to the partner or to a trusted friend.

> "I guess my mom because she listens to me, she advises me a lot when I am in trouble, we share." (P8)

> "I told my friend and she advised me to do abortion." (P27)

> "My boyfriend accepted it well."(P11)

Keeping TOP a secret seems to be one of the reasons that might contribute to women experiencing negative emotional, physical and social effects after TOP. Some women indicated that they did not want to share the secret with anyone.

Van der Walt (2015:28) found that very often women will struggle emotionally following abortion. The situation will be worse if there is no one to offer support. Even if a woman was confident about terminating the pregnancy, the intense emotions may surface.

**Sub-theme 3.2.3: Relationship with community**

**Sub-theme 3.2.3.1: Fear of being ostracised**

Most of the participants were aware that the community and the society label, reject or discredit women who terminated pregnancies, even though they are not aware of their reasons. According to Goffman (1963 as cited in Agunbiade 2009:6), stigma represents the incidence whereby an individual with an attribute is deeply discredited or rejected by his/her society as a result of the characteristic. It is influenced negatively by the reaction of others. Some members of society reject women who terminated pregnancy and react negatively to them. Participants expressed the following fears:

> "…people will see me as a murderer…it may not be acceptable…" (P1)

> "I fear people will speak badly of me that I terminated pregnancy…a woman is not accepted in the community after TOP." (P5)
> "You can't spread it to others; you are still scared about it…you don't tell others what you did because you did exactly what your parents told you not to do." (P6)

> "They judge you. Painful to be judged when a person does not know the reasons for TOP." (P7)

> "…I feared sharing because people take abortion to be wrong…"(P11)

> "I know they are judgmental…" (P13)

> "You know some people can judge you, but I will say if those people can put themselves in your shoes, they will understand what you are going through & they wouldn't be judgemental…" (P18)

According to Agunbiade et al (2009:6), stigma exists for the following reasons:

- People label human differences.
- Dominant cultures link labelled persons to undesirable characteristics.
- Labelled persons are separated as "us" from "them".
- Stigmatisation allows the identification of differences, leading to disapproval, stereotypes, rejection, exclusion, and discrimination.
- Families, churches, communities, and societies manifest these components in the social construction of TOP.

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Such negative meanings may be effective as society's wisdom in restraining adolescent pregnancy and everything that has to do with it, including TOP. On the contrary, negative sentiments become dysfunctional and destructive to adolescents who end up hiding any information about their need for emotional support and care after going through TOP. Undergoing TOP in silence, as well as having to device coping tactics related to the aftermath of TOP, is usually traumatic for the adolescents (Agunbiade et al 2009:6).

**Sub-theme 3.2.3.2: Relationship with church**

Of the 30 participants, 28 indicated that they belonged to the Christian faith, one belonged to the Islamic faith and one was an atheist. All the Christians indicated that they belonged to a denomination, but after members did TOP some churches did not allow their members to attend church for three to six months, for fear of contaminating the church spirit. Other participants stopped attending church for some time because they felt guilty of having done TOP.

On relationship with the church, participants had this to say:

> "I stopped going to church for 3 months, because church law does not allow attending church when you have done TOP because this contaminates the church." (P2)

> "…at my church they gave me six months to stay by myself, away from church…" (P9)

> "…so I don't feel like going to church, it's a very big deal."(P13)

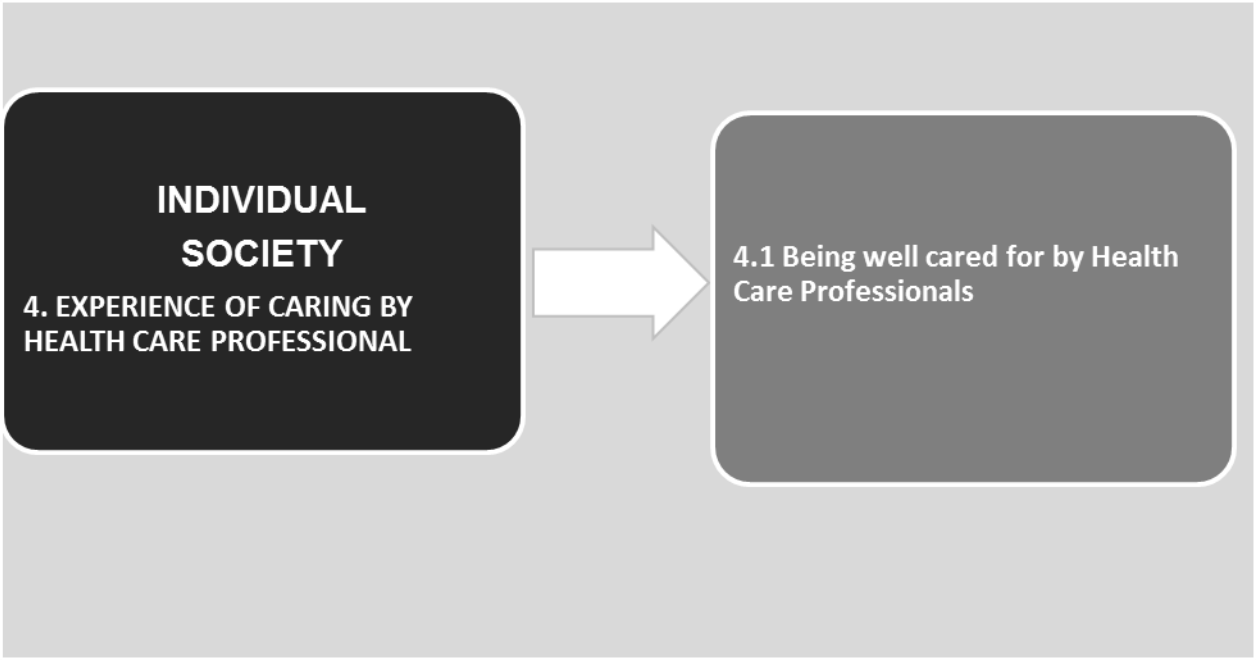
> "I pray that one day I can go to church" (P15)

> "…sometimes I go to church sometimes I do not go. Sometime I take six months or nine months not going to church." (P30)

> "…I stopped going to church because it's like I am liar in the face of God. I may ask something from God but God will know I am murderer…" (P23)

Even outside the church, they all stated that they continued to pray and ask for forgiveness from God. Attending church was found to be important for participants especially at the time when they needed forgiveness from God.

#### *4.3.4.4 Theme 4: Experience of caring by health care professionals*




**Subtheme 4.1: Being well cared for by HCP**

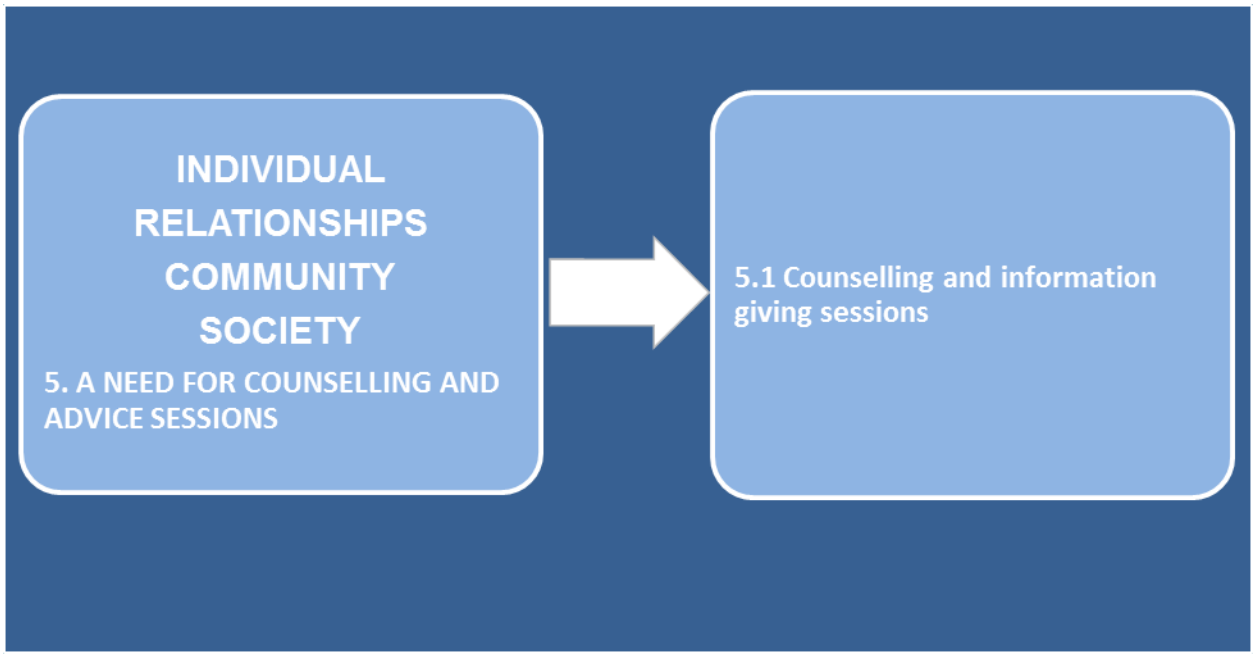
Health care professionals at the TOP clinic were praised by 29 participants, that they treated participants well, patiently and with love.

The following statements confirm:

> "…I liked the way she treated us, she was not harsh on us, she was kind and she was open to us…not afraid to ask questions, due to the way she approached us…" (P19)
>
> With love…she is loving, the sister." (P1)
>
> "They treated me well…they are good, patient, they treat people well…" (P5)
>
> "…I was treated well and follow up treatments have also went well…they showed love, they showed humanity." (P9)
>
> "…the sister treated me well…" (P12)
>
> "supportive and positive…" (P3)

Participants appreciated the good treatment because most said that they come to the clinic still confused, not knowing whether to do TOP or not. Therefore, if the clinic personnel is unfriendly to them, it causes even more confusion.

#### *4.3.4.5 Theme 5: A need for counselling and advice sessions*




**Sub-theme 5.1: Counselling and information giving sessions**

Participants stated that they need pre-counselling as well as post-counselling. The following statements summarise the participants' expressions:

> "…ask her to take about a week to think about termination before it is done, then come back on such and such a date." (P3)

> "I wish a professional person, a sister or you (researcher) can tell me what I have done is not a bad thing…because they will tell me the truth, they won't tell me what will break my heart, or cause my heart to sink, because right now I don't know the truth…I am just hanging in the air…I made a mistake to myself." (P2)

> "…before everything she explained the whole procedure…on how it works…" (P19)

"…Counselling, because talking about it is important…then they can help you on the right path." (P1)

"…sister should speak to me about my feelings. She must uplift and encourage me." (P5)

"…Sister gave us papers that told us about risks of TOP….that the risks are there…" (P2)

"…she should tell you what will happen after termination…that you should tell someone about it & you could lose your life…" (P1)

Major points raised by participants about the information session were:

- That the TOP unit manager must give them about a week to go and think about TOP, then come back after deciding.
- Explain the procedure before terminating.
- The unit manager should tell the client about the feelings she will experience after TOP.
- She should tell the client about what will happen after TOP.
- Should tell the client that for support, she must inform someone about her TOP.
- The unit manager should warn the patient that she can lose her life.
- Talk about confidentiality.
- To be told that what the client has done is not a bad thing and she is not the only one. Tell the client the truth about TOP.

## 4.4 FUNDAMENTAL STRUCTURE OF THE PHENOMENON

According to Colaizzi (1978 as cited in Polit & Beck 2014:406), step 6, which follows the integration of results into an exhaustive description of the phenomenon of TOP and related guilt, involved description of the phenomenon as clearly as possible. The exhaustive description is revised into a more condensed statement of the identification of the fundamental structure of TOP and related guilt, as well as the journey of self-forgiveness. The fundamental statement was member-checked with some of the participants to validate how well it caught their experiences.

**A shift from an unplanned or unwanted pregnancy to a spiritual turmoil**

The depth of guilt as related to TOP far exceeded the confines of the experience of TOP - the guilt was deeply spiritual. The decision-making process leading to TOP was burdened with confusion, and the aftermath of TOP was clouded with an awareness that the women murdered of their own babies. Some felt that because they did not hold a proper ceremony to bid their babies a proper goodbye, it causes them to refuse to forgive themselves. The accompanying guilt, spiritual desertion, aloneness, shame, emotional pain, sadness, depression, sleeplessness, anxiety, and anger rendered some helpless. Finding no answers to this predicament, many got anchored on a spiritual relationship with The Higher Being, God. According to many participants, only He understood the situations that forced them to terminate their pregnancies. Moreover, a few others who were still angry, felt rejected by God.

Many therefore strategised to claim forgiveness for their sin of murder, within which their guilt is embedded, so that they can subsequently forgive themselves or accept themselves as flawed. With this courage, many never shared with others about their experience of TOP for fear of being judged by partners, family, the church, the community, as well as the society. They continued to privately pray to God for forgiveness. Most participants were aware that forgiveness is a process, not an overnight solution. Those who do not know about self-forgiveness were willing to learn about it so that they continue their life journeys free of guilt. A few who were still deeply struggling with the thoughts about the experience of TOP, felt they needed somebody to speak to, somebody who would not break their spirit, but would tell them the truth about TOP, and that they did not do any wrong.

Other strategies entailed rituals like drinking special tea that has been prayed for, or drinking traditional herbs for body cleansing, as well as avoiding contact with children or partners for some period. Women who felt that they were on their way to forgiving themselves sounded confident and in control of their lives. The role of health professionals that assisted with TOP was seen as positive, supportive and as restoring their dignity and self-respect. Only one participant felt judged, specifically by a group of nurses in a hospital. The experience left her angry. Although there is hope for healing

after self-forgiveness, many stated that they will never forget their babies that they "murdered" and that they (their babies) will remain part of their lives.

## 4.5 CONCLUSION

This chapter focused on data analysis, findings and literature control. The main themes outlined were based on:

- The experience of TOP.
- Unplanned pregnancy.
- Intra and interpersonal relationships.
- Experience of caring by health care professionals.
- A need for counselling and advice sessions.

As a summary of the discussions and findings, a section on the fundamental structure of the phenomenon was included.

# CHAPTER 5

# DISCUSSION OF MAJOR FINDINGS

## 5.1 INTRODUCTION

The previous chapter focused on data analysis, findings and literature control. The main themes outlined were based on the experience of TOP, unplanned pregnancy, intra and interpersonal relationships, experience of caring by health care professionals and a need for counselling and advice sessions. The discussions are underpinned by SEM, which is a validated framework in Health Sciences.

This chapter will focus on the discussion of the main research findings, incorporating the data obtained from participants. The present study investigated self-forgiveness among women who terminated pregnancy during adolescence. The discussion of the research findings will be within the context of the participants' own understanding and explanation of their subjective experiences as well as the meanings they create about TOP during adolescence. The emphasis will be placed on a discussion of the cultural and religious expositions, self-blame and self-condemnation, intimate partner violence, including reproductive coercion.

### 5.1.1 Cultural factors

Culture refers to the widely shared customs, beliefs, values, norms, institutions, and other products of a community that are transmitted socially across generations. It encompasses everything from a society's legal system to its assumptions about family roles, dietary habits, attitudes about time, technology, modes of dress, spiritual beliefs, art, to its unspoken rules about sexual relationships, among others (Weiten 2013:25). Even the understanding of life power as well as gender relations are an expression of culture. It is a strong concept by which every group of people are identified.

The concept of culture can be applied to entire societies, from broad ethnic groups, to small groups and to non-ethnical groups like women or men. According to Triandis (2007 as cited in Weiten 2013:26), culture exists outside people (expressed as customs,

for example) or inside people (as what happens to other people is viewed through a way of thinking). Cultural background is widely shared and members usually take it for granted.

In the Black culture, a woman who cannot bear children is belittled. Derogative Tswana terms applied to such women, like ‘moopa’ (a barren woman) or ‘monna’ (a male) reveal that culturally such women are demeaned in the community. The fear of not being able to conceive was probably escalated by the guilt of having murdered their babies, and most participants felt it was one of the punishments they deserved.

According to Turyomumazima (2017:1), Africans believe that “unhappy is the woman who fails to get children for,…she has become the dead end of human life,…also for herself”. Turyomumazima (2017:2) also explains that a child is thought to be a re-incarnation of the departed. Therefore, a woman without children extinguishes the fire of life by blocking her line of physical continuation.

The birth of a child is perceived as a blessing to parents and relatives, including the dead (Turyomumazima 2017:2). This is so because it is the community who must protect, feed, bring it up, educate it and incorporate it into the wider community. In Africa, the child is “ours”, not “mine”. In this setup, there are no abandoned children, even those born out of wedlock, hence abortion is non-existent in an African culture (Thupayagale-Tshweneagae, Dithole, & Seloilwe 2015:17). In the occurrence of an abortion that is not self-inflicted, there are certain cultural rituals, commonly referred to as cleansing of the body and blood that should be followed (ibid).

Body and blood cleansing is related to the ability to conceive in future. The assumption is that if this cleansing is not done, the women will be prone to illness, bad luck and may not conceive and men who get in contact with her sexually, may also become sick or even die (Turyomumazima 2017:2). Almost all participants in this study were Black women and fertility is culturally very important for their mental well-being and acceptance in their communities. Inability to ever conceive resulted in most participants in the study worried and feeling guilty, as since the abortion was secret, their cleansing should also be conducted in secrecy. It is worth mentioning that at least two of the participants went into their cleansing on their own. Some women, after TOP, are known to keep the sanitary pads for a period of time and allowed them to be swept away by the

flowing water in the river (Sebola 2014: Annexure E). All these acts show the value still attached to culture.

Arrival of a healthy child to parents indicated a healthy relationship between the parents, relatives, ancestors, and God Himself. During pregnancy therefore, parents are expected to be of good moral standing for the birth for the child to go smoothly. African cultural and religious values have made TOP a taboo. As Landman and Barry (2002) as cited in Turyomumazima (2017:3), pointed out, even though TOP is now legal in a number of countries in Africa, including South Africa, the attitudes towards TOP have not changed.

According to Black culture, even death of a foetus is regarded as *"sefifi*", meaning darkness and this is associated with misfortune in all areas of one's life (Conversation with traditional leader, 25th August 2016). This is why even after TOP, some participants needed their bodies and their "*blood*" to be cleansed by drinking and bathing with traditional herbs, drink special tea or special water that has been prayed for by their church "prophets" or pastors. It is within this cultural belief system that TOP brings about guilt and shame as participants feel they have transgressed from normal cultural practice.

Even though a larger percentage of the indigenous population are converts to Christianity, it is the indigenous beliefs and values, which mainly serve as facilitation for their religious and cultural expression. Body cleansing is carried out because culture teaches that after death of a foetus, the woman's blood is left dirty and she can cause other people diseases or even death. Other traditional practices involved abstaining from intimate sexual relations with men (partner or husband) for three to six months, not cooking food for the family for about three to six months or staying away from church for three to six months, depending on the church rules. These cultural practices are carried out because TOP is regarded as murder and death and that it contaminates the woman's body. After TOP, a woman would observe these rituals alone in secrecy. After a loss of pregnancy, there are cultural rituals that have to be followed. Oftentimes, the adolescent may not even know what she has to do and would only do these that she remembers or has heard of. This in itself brings strain and mental torture to the adolescent. Support of family and friends is essential in any mourning (Angelo 2011:2). In this situation, an adolescent takes a lonely and unfamiliar journey by herself. If she is

without support, it can be a lonely time for her, more so because women who aborted are not allowed to mourn the death of their babies even though they need support of their partners or family members at this time.

Health professionals need to always agree with the woman about the disposal of the foetus and the products of conception. Practices like burial of the dead need to be discussed with the woman who terminated pregnancy so that if there is need for such a practice it can be attended to. If the woman feels that the foetus was not properly disposed of with dignity, as according to her culture, it can cause her to find it difficult to find emotional healing and closure, especially if she saw the products of conception.

After abortion, the woman may feel grief that is usually blunted by strong conflicting feelings related to her motherly mental state about the aborted baby and a defensive denial of these feelings that enabled her to submit to the TOP procedure (Angelo 2011:1). Expectations of the society are that she feels relieved, while in reality she is often overwhelmed by guilt, and shame and needs emotional healing. Most of the time, as in the present study, the relationship with the parental father ends abruptly for a number of reasons. Unlike other deaths, there is no consolation from family and friends who most often are unaware of TOP or may have pressurised her to terminate her pregnancy. As Angelo (2011:2) emphasises, they need supportive care; they need therapy where care should be taken so that re-living the experience of abortion does not cause post-traumatic stress. Therefore, there is a great need for supportive care and counselling from health care practitioners so that emotional healing will begin.

### 5.1.2 Religious factors

The majority of the participants were Christians. Religious ideology and practices have established male-dominance in decision-making, including decisions about reproduction (Moloko-Phiri 2015:158). The Christian religion regards TOP as a sin of murder. As a result, the majority of participants in the present study regarded TOP as sin of murder and stated that they are murderers. For the adolescents, spirituality plays an important role in death and loss and so losing a pregnancy through TOP provoked questions about values as well as the meaning of life and death (Curley & Johnston 2014).

Almost all participants interviewed were convinced that they needed to remain connected to God because they were aware of their sin of having terminated their pregnancies and they therefore feared God's punishment or God refusing them to enter heaven when they die. As a result, the experience of guilt brought them closer to God through prayer for forgiveness, attending church and studying the Bible.

People with heartfelt religious convictions, according to Abdel-Khalek (2006 as cited in Weiten 2013:406), are more likely to be happy than people who are non-religious.

As Myers (1992 as cited in Weiten 2013:406) discussed, religion can give people a sense of purpose and meaning about their experiences in their lives. Women who expressed their relationship with God and believed that God would forgive them had a purpose and their experiences about TOP were meaningful to them. As a result, they did not feel hopeless. Some believed that after God has forgiven them, they would be able to forgive themselves. Self-forgiveness is about accepting one's flaws and religion helps people to accept their setbacks gracefully (Weiten 2013:406). Remaining in the church community could help these women to connect to caring and supportive people within the church (Weiten 2013:406). From the study findings, a significant number of participants (10) reported to be not ready to go back to church.

The Christian religion regards TOP as a sin of murder. The Holy Scriptures and church tradition emphasise the sacredness of life and the dignity of every human being. As Turyomumazima (2017:1) notes, Christianity condemns TOP. According to Turyomumazima (2017:1), in traditional Africa, children are highly valued in society and are regarded as precious. As marriage and procreation in Africa are a unity, without procreation marriage is incomplete until a wife has given birth. Even expectant African mothers receive special treatment from relatives and neighbours. Some participants were concerned about the likelihood of their inability to conceive after TOP. The TOP clinic manager usually explains this risk to them after TOP as one of the possible complications.

### 5.1.3 Self-blame and self-condemnation

Blaming oneself is a common response when people are confronted by stressful difficulties. The tendency to become highly critical of self in response to stress causes,

aggravates and perpetuates emotional reactions to stress. Negative self-talk can contribute to development of depression and other psychological problems (Weiten 2013:547).

Most participants posited that they were feeling sad and guilty. The sadness and the guilt were related to an understanding that they killed their innocent babies or innocent blood. Very few stated that their babies were not yet formed but most participants acknowledged that they killed their babies and were murderers.

The self-blame and condemnation also led to shame. The emotion of shame is strongly unpleasant, and it involves negative emotions directed at the whole self, therefore making self-forgiveness more difficult (Tangney & Dearing, 2002 as cited in Fisher & Exline 2010:551).

Women who expressed that they are murderers actually experience shame and those who stated that they have killed their babies were guilty. According to Fisher and Exline (2010:551), women who experience shame focused more on condemning themselves instead of focusing on building a positive relationship with the person they wronged. They will report feeling stressed, small, worthless, powerless, and having a sense of being exposed and wanting to hide. Rangganadhan and Todorov (2010:15) explain that people high on shame are also higher on personal distress empathy, meaning that they find it difficult to reach internal acceptance of self.

On the contrary, guilt is an emotion that focuses on the wrong behaviour and on the person who is wronged. It is linked to empathic behaviour. Guilty people feel remorse about their offence and are likely to repent of their transgression, accept responsibility for their wrong and express a humbled character (Rangganadhan & Todorov 2010:553). The problem about TOP is that the damage cannot be reversed, and the aborted baby cannot be brought back to life.

As Rangganadhan and Todorov (2010:553) note, there are situations in which high levels of guilt and remorse - which can be useful in the right amounts and in the right context - can backfire and become stressful. Some women who feel guilty, but find that their reparative behaviours are not possible or are insufficient, as it may inevitably be the case after TOP, may turn to self-punishment. In the present study, some women, in

an attempt to restore a sense of justice through their own suffering, self-condemnation or self-blame, stopped attending church for some time because they believed that they were '*dirty*' and needed to cleanse themselves first while others referred to themselves as murderers. Shame-prone transgressors may avoid conciliatory behaviours because they believe that changing themselves is impossible (McConnel, Dixon & Finch 2012:1932).

To deal with guilt, other participants stated that they turned to God through prayer, to ask for forgiveness of their sin of TOP. Some of these women specified that they needed God to forgive them so that they could forgive themselves. Not every woman knew about self-forgiveness, shame and guilt. Therefore, it is important that women who are laden with guilt and shame be taught about these painful, intropunitive feelings and about the differences between these emotions. The understanding arising from such teaching will help such women to stop or reduce their self-condemnation. To resolve negative self-evaluations, guilty women may want to self-forgive, whereas shame-prone women will want to withdraw from people and avoid the motivation to self-forgive (McConnel et al 2012:1933). As a result, McConnel et al (2012:1933) warn that some people who may openly deny self-forgiveness and appear shameless, could actually be hurting inside.

### 5.1.4 Intimate partner violence, including reproductive coercion

Intimate partner violence is a more inclusive concept which does not only refer to abusive behaviour in a marital relationship, but also takes account of abusive behaviour in a cohabiting relationship where the couple is not married (Bezuidenhout 2017:15). It is estimated that in South Africa, one in four women is or has been a victim of domestic violence.

As cited by Moloko-Phiri (2015:145), Ushine et al (2010:76) found that abuse happen to all women and may leave them with physical and mental illnesses. The phenomenon cuts across age, religion, culture, level of education and economic status.

In the present study, some women experienced physical abuse at the hands of their partners after falling pregnant. Subsequently, these participants feared revealing their pregnancies to these partners. They were compelled to decide on TOP alone. A few

were sometimes forced into sexual relations, which led to pregnancy. Alcoholism was one of the causes of violence from the partner with one of the participants. One of the participants was forced not to use contraceptives. Conflict with partners caused participants to terminate the relationships and the pregnancies.

A few experienced emotional abuse from partners. One woman reported that the partner controlled her regarding her socialisation with other people. For peace, she had to pay with her body, and hence a need to terminate her pregnancy. Most of the participants in the study reported having been coerced into sexual relations that led to their pregnancy. According to Seloilwe and Tshweneagae (2010:4), forced sexual relations is one of the commonest RC at times referred to as intimate partner rape.

### 5.1.5 Gender roles

In a patriarchal country like Africa, most women are subordinate to their partners because of gender inequalities. Women's role within the family is mainly reproductive. A woman's value is measured by her ability to reproduce. The low status of women may be caused by low level of education, financial dependence on men among others.

In the present study, most of the participants revealed that they stopped their relationships owing to the partner's infidelity, lack of his financial support, physical abuse or the partner just disappearing after learning about the pregnancy. Most women were left by their partners and few decided to not to leave in order to fulfil their roles (Achulu 2011:248). On the contrary, some women were forced by their partners to terminate their pregnancies against their will. As women, they had to agree even though they will then carry the burden of guilt alone.

This socialisation causes men to find it difficult to understand that a woman can make a decision in a household, including decisions about her own sexuality, family planning methods, how and when to have children (Achulu 2011:248). Women in abusive relationships are reported to have low self-esteem, low morale and blame themselves for the abuse they face, leaving them feeling isolated, hopeless, and helpless (Moloko-Phiri 2015:148). Women who feel very reliant on their partners for financial support usually have no decision-making power on issues that affect them like pregnancy and

pregnancy outcome. Such women develop feelings of inadequacy and powerlessness (Moloko-Phiri 2015:149).

For fear of violence, women in abusive relationships and who do not have the financial means to leave their abusers are often unable to negotiate for safe sex and they thereby report a higher rate of unwanted or unplanned pregnancies (Moloko-Phiri 2015:150). The implication is that abused women have no voice, no negotiating power, and no way to avoid unsafe sex (Moloko-Phiri 2015:150). All these problems are linked with gender roles as dictated by both culture and religion.

## 5.2 CONCLUSION

Cultural and religious expositions, self-blame and condemnation, including intimate partner violence with reproductive coercion were the key findings of the study. The findings are well supported in literature, except for cultural and religious expositions, which although studied before did not necessarily have relevance to TOP. Therefore, the idea of self-blame and condemnation as espoused in this study has long-term effects on the health of adolescents and their transition to adulthood. The findings form a foundation of the self-forgiveness model development.

# CHAPTER 6

# PHASE 3: DEVELOPMENT OF A MODEL

**“**We can never obtain peace in the outer world until we make peace with ourselves.”
(Dalai Lama XIV).

## 6.1 INTRODUCTION

Self-forgiveness has intrapersonal and interpersonal benefits. Counsellors are encouraged to consider self-forgiveness as a treatment goal for women struggling with the negative consequences of terminating a pregnancy (Cornish & Wade 2015:96). Different models that have been used to allow for self-forgiveness have influenced the developed model.

Offending or harming others, as well as failing to act in a way that would prevent offending others or self, is an inevitable part of life. This can range from minor offences to more severe acts of harm to others, such as committing murder. Importantly, misbehaviour can also cause harm to self, for example, violating one’s values or morals. Causing significant harm to another person or to self can later cause the offender sorrow, self-resentment, self-blame, shame, or guilt (Baumeister & Leary 1997; Tangney & Dearing 2003). Although such feelings commonly occur, their continuation and the development of harsh and self-critical feelings may be damaging to both the offender and the victim, hindering both psychological and physiological well-being (Cornish & Wade 2015:96). It is within this premise that individuals should learn to abandon self-resentment and to self-forgive. Self-forgiving leads to significant personal growth and renewed mental health (Cornish & Wade 2015:96; Wohl & McLaughlin 2014:422). Other researchers (Romero, Kalidas, Elledge, Chang, Liscum & Friedman 2006, Thompson, Snyder, Hoffman, Rasmussen, Billings, Heinze, Neufeld, Shorey, Roberts & Roberts 2005, Fisher & Exline 2006, Woodyatt & Wenzel 2013 as cited in Cornish & Wade 2015:96), further reported that self-forgiving leads to increase on self-esteem, perceived quality of life, satisfaction with life and emotional stability.

The development of self-compassion or self-acceptance is indispensable in several forms of counselling, including acceptance and commitment therapy (Hayes, Strosahl & Wilson 2003 as cited in Cornish & Wade 2015:96) and emotion-focused therapy (Greenberg, 2002 as cited in Cornish & Wade 2015:96). According to Cornish and Wade (2015:96), applying these concepts to specific situations in which clients have hurt others or themselves will likely lead to positive psychological outcomes. However, the way that self-compassion and self-acceptance are developed after a specific offence matters and a clear understanding of what is meant by self-forgiveness is important.

The purpose of this chapter was to provide a model that will provide health professionals who are involved in counselling women who terminated pregnancies and are laden with guilt, shame, regret, and personal distress empathy, with direction on how to promote self-forgiveness in these clients. Having discussed the main findings of the study in the previous chapter, the researcher will assemble the abstractions of the main findings to formulate a model of self-forgiveness for women who terminated pregnancy during adolescence.

Through this model, the phenomena of guilt, shame and self-forgiveness among women who terminated pregnancy during adolescence will be represented with minimal words. Polit and Beck (2014:134) attest that visual or symbolic representations of a phenomenon are helpful in expressing abstract ideas more clearly and minimises the words used. There are two types of models used in research contexts, namely, the statistical model and the schematic models. In the present study, the researcher will develop a schematic model to express self-forgiveness for women who terminated pregnancy during adolescence. Schematic models or conceptual models visually represent relationships among phenomena, and are used in both qualitative and quantitative research. Concepts and linkages between them are depicted graphically through boxes, arrows or other symbols (Polit & Beck 2014:133).

The function of a conceptual model is to broadly present an understanding of the phenomenon of interest and reflect the assumptions and philosophical views of the model's designer. Models can serve as facilitators for generating hypotheses. The purpose of this research was to provide health professionals involved in counselling

women who terminated pregnancies with direction on how to promote self-forgiveness in clients who have harmed others, including themselves.

## 6.2 THE INFLUENCING MODELS

The following models influenced the model developed for the present study:

- The Self-forgiveness model of Hall and Fincham (2005; 2008).
- The Therapeutic model of self-forgiveness by Cornish and Wade (2015).
- Rangganadhan and Todorov (2010:6) proposed model of self-forgiveness.
- The social ecological model (Grabbe et al 2016:240).

None of the models that influenced the current model was conclusive by itself, hence ideas from these models were integrated.

### 6.2.1 The Self-forgiveness Model of Hall and Fincham (2005; 2008)

Hall and Fincham (2008:175), contributed to the model by highlighting that self-forgiveness is a process that unfolds over time and is not linear, as offenders may fluctuate between self-acceptance and self-condemning. For one to forgive the self it is important to make continued reparations to the victim of one's offence or resolving to never again commit such an offence (Hall & Fincham 2008:176). Therefore, in reconstructing, which is part of the SF model, reconciliation with the self is a necessary aspect of intrapersonal forgiveness (Enright, 1996 cited in Hall & Fincham 2008:176).

#### *6.2.1.1 The temporal course of self-forgiveness*

Self-forgiveness unfolds over time. Hall and Fincham (2008:176) assert that self-forgiveness is best understood by examining it from the time of the transgression. Although some scholars argue self-forgiveness, it is non-linear, as offenders may fluctuate between self-acceptance and self-condemning (Enright 1996 cited in Hall & Fincham 2008:177). However, it can stabilise over time, or the rate of change may vary.

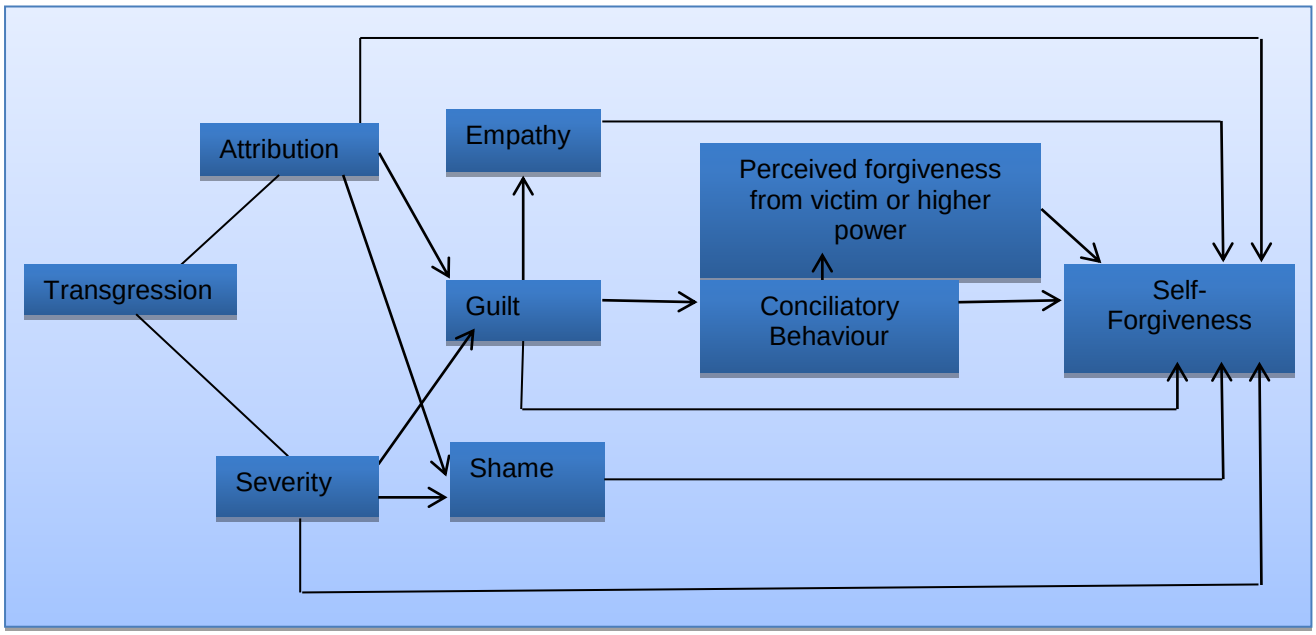



**Figure 6.1 Hall and Fincham's proposed model of self-forgiveness (2005)**

(Hall & Fincham 2005)

#### *6.2.1.2 Correlates of self-forgiveness*

According to Hall and Fincham (2008:177), the motivational shift is driven by changes in emotional (shame, guilt, empathy), social-cognitive (attributions, perceived forgiveness), behavioural (conciliatory behaviour) and offence-related variables (perceived transgression severity). Intrapersonal forgiveness can take several forms, for example, state versus trait, and can focus on different types of offences (for example, transgressions against the self, against the others, against a Higher Being). Correlates included in this model intentionally omit certain variables such as personality characteristics, in lieu of offence-specific variables (Hall & Fincham 2008:177).

The authors contend that although dispositional factors are important in self-forgiveness, personality factors are likely more distally related to self-forgiveness than the variables proposed in this model. According to Hall and Fincham (2008:174), self-forgiveness increases linearly over time and it is a dynamic process associated with many factors.

- **Emotional correlates (shame, guilt, empathy)**

Shame and guilt are assumed as primary emotional correlates of self-forgiveness, with guilt focusing on one's negative behaviour and shame associated with a negative focus on the self. Decrease in shame and guilt over time will be associated with increase in self-forgiveness, whereas greater levels of shame and guilt will be associated with lower levels of self-forgiveness (Hall & Fincham 2008:179). Moreover, drop in shame and guilt inhibits acting negatively towards self and encourages acting kindly towards the self. In support of Zechmeister and Romero (2002), Hall and Fincham (2008) allude that self-forgiving individuals are less likely to report guilt than those that had not forgiven themselves.

Empathy towards the person offended is expected to be negatively related to self-forgiveness because the concern of empathic transgressors over those they offended cause them to find it difficult to forgive themselves (Hall & Fincham 2008:179). The authors expect that a decrease of empathy within individuals over time will enable them to change their focus from the victim to the self and to replace negative emotions toward the self with more positive feelings by shifting their perspective. Zechmeister and Romero (2002 as cited in Hall & Fincham 2008:180), found that individuals who forgave themselves are less likely to be empathic than individuals who have not forgiven themselves.

In light of the finding that the ability to empathise is not related to self-forgiveness, Barbetta (2002 as cited in Hall & Fincham 2008:180), indicate that this association between empathy and self-forgiveness is tentative.

- **Social cognitive correlates (attributions and perceived forgiveness)**

According to Hall and Fincham (2008:180), external, unstable and specific forgiveness-promoting attributions for one's behaviour will be linked to greater self-forgiveness, while the internal, stable and global forgiveness-inhibiting attributions will be related to lower levels of self-forgiveness. Furthermore, Hall and Fincham (2008:180) note that within individuals, it is expected that a decrease in forgiveness-inhibiting attributions will, over time, be related to an increase in self-forgiveness. In Hall and Fincham's (2005)

model of self-forgiveness, attributions are distally located meaning that they may be weakly associated with the process of self-forgiveness.

A more proximal covariate of self-forgiveness may be the extent to which an offender believes that others forgive him for the offence (Hall & Fincham 2008:180). This perceived forgiveness from the victim and from the Higher Power is hypothesised to be positively associated with self-forgiveness. It is also expected that increase in perceived forgiveness within individuals across time will be linked to increase in self-forgiveness because when one is granted forgiveness for an offence, one is inclined to be at peace with one's behaviour. Nevertheless, tests to these predictions by Witvliet, Ludwig and Bauer (2002 as cited in Hall & Fincham 2008:180), found that an offender's response to the victim's mercy was associated with self-forgiveness. In contrast, Zechmeister and Romero (2002 cited in Hall and Fincham 2008:180) did not find an association between self-forgiveness and reports of being forgiven by the victim.

The authors further state that spirituality is uniquely and distinctly related to self-forgiveness and therefore greater perceived forgiveness from a Higher Power will be associated with higher levels of self-forgiveness. In the same vein, Cafaro and Exline (2003 as cited in Hall and Fincham 2008:181) support this idea from a study that found that self-forgiveness was positively associated with believing that God had forgiven the self for a transgression. Subsequently, increases in perceived forgiveness from a Higher Power within individuals and from the victim will be strongly linked to increases in self-forgiveness.

- **Behavioural correlates (conciliatory behaviour)**

Conciliatory behaviours, such as apologising, making amends and seeking forgiveness would be related to self-forgiveness. Such conciliatory behaviour could be directed at the victim of the offence and/or at a Higher Power and may facilitate self-forgiveness by alleviating the offender's guilt and shame about the transgression (Goffman, 1971 as cited in Hall & Fincham 2008: 181). In addition, Zechmeister and Romero (2002) observed that individuals who are able to forgive themselves are more likely to report engaging in conciliatory behaviours toward the victim than individuals who are unable to forgive themselves. Moreover, increases in conciliatory behaviour within individuals over time will be associated with increase in self-forgiveness, as perceptions of self-

forgiveness tend to increase when offenders imagine seeking forgiveness from someone, they have wronged (Witvliet et al 2002). Therefore, Hall and Fincham (2008:182) hint that the spiritual and the non-spiritual realms of conciliatory behaviour should be considered separately. The result of the study examining temporal course of self-forgiveness (Hall & Fincham 2008) confirmed that decrease in conciliatory behaviour was associated with increase in self-forgiveness.

- **Offence-related correlates (perceived severity of the offence)**

Hall and Fincham (2008:182) expect perceived severity of the offence to be associated with lower levels of self-forgiveness, because some offences are more severe than others. Even with a serious transgression, the offender may realise some positive outcomes of the transgression (Hall & Fincham 2008:182). For example, an offender may feel that she has grown from the occurrence or that her post-offence relationship with the victim is stronger. Therefore, according to Hall and Fisher (2008:182), self-forgiving offenders report more positive consequences and fewer lasting negative consequences of the transgression than do offenders who have not forgiven themselves. In addition, that decreases in perceived severity within individuals will be associated with increases in self-forgiveness over time. In the Hall and Fincham (2008) conceptual model, transgression severity is distally located and may be weakly associated with self-forgiveness. The result of a study examining temporal course of self-forgiveness (Hall & Fincham 2008) confirmed that decrease in perceived transgression severity was associated with increase in self-forgiveness.

### 6.2.2 The Therapeutic process model of self-forgiveness by Cornish and Wade (2015)

Cornish and Wade (2015: 97) support that the self-forgiveness process can be seen as involving four components, which the authors term the four R's of genuine self-forgiveness: responsibility, remorse, restoration and renewal (see Table 6.1). All the four Rs are important aspects of the model of self-forgiveness related to women who terminated pregnancy in adolescence.

**Table 6.1 The four Rs of genuine self-forgiveness**

| Component | Description |
|---|---|
| Responsibility | The offender taking responsibility for his/her actions and the effects of those actions. Responsibility minimises blame-shifting. |
| Remorse | The offending person may experience a wide range of emotions because of responsibility. At this stage shame-based, that is, global responses need to be worked through and reduced, leaving behind more appropriate, remorse-based, that is, offense- specific responses such as guilt and regret. |
| Restoration | An action-oriented step following from responsibility and remorse. In genuine self-forgiveness, the offender seeks to make amends and repair the damage as much as it is possible.<br>Behaviour patterns that led to the offense are also addressed and the values violated by the offense are reaffirmed. |
| Renewal | The offending person obtains the emotional state of self-forgiveness, involving renewed compassion, acceptance and respect for oneself. Moral growth has occurred from the process of working toward self-forgiveness. |

The authors noted that even though the components can be thought of sequentially, they are also interrelated (Cornish & Wade 2015:97).

- **Responsibility**

Accepting responsibility for an offence threatens one's self-regard or status (Wenzel, Woodyatt & Hedrick 2012 as cited in Cornish & Wade 2015:97). However, avoiding responsibility is not conducive to self-forgiveness. Genuine self-forgiveness relies on the transgressor's acceptance of responsibility for the offence.

If responsibility acceptance is omitted, pseudo self-forgiveness results instead, in which the offender excuses, justifies or rationalises the offence, sometimes shifting the blame to other people (Hall & Fincham 2005:626; Woodyatt & Wenzel 2013 as cited in Cornish & Wade 2015:97), instead of accepting responsibility for her role in the offence (Jacinto & Edwards 2011 as cited in Cornish & Wade 2015: 97).

According to Cornish and Wade (2015:97), accepting responsibility includes recognition of wrongdoing, acknowledgement that one could and should have done things differently, and a realisation of one's imperfection (Holmgren 1998 as cited in Cornish &

Wade 2015:97). Acceptance of responsibility also brings more affective reaction that can include remorse, shame and guilt (Hall & Fincham 2008; Fisher & Exline 2006 as cited in Cornish & Wade 2015:97), that must be worked through.

- **Remorse**

Negative feelings related to TOP or having harmed oneself can be overwhelming. Nevertheless, acknowledgement and expression of the negative feelings associated with the offence has been suggested as an important part of self-forgiveness (Enright & The Human Development Study Group 1996 as cited in Cornish & Wade 2015:97) because it may encourage the offender to connect to the reality of the harm caused. Any attempts to forgive oneself without confessing one's emotional reactions would likely make true internal resolution of the offense difficult (Holmgren 1998 as cited in Cornish & Wade 2015:97).

Emotional reactions following an offence fall into two all-embracing categories: guilt (remorse) and shame. Guilt involves tension, remorse, and regret about one's actions. In contrast, in shame, the negative feelings are focused on self, not on the regretted actions (Tangney & Dearing 2002 as cited in Cornish & Wade 2015:97). According to Lewis (1971:30 as cited in Cornish & Wade 2015:97), the experience of shame is directly about the self, which is the focus of evaluation, whereas in guilt, the self is not the central object of negative evaluation, but rather the *thing* done or not done is the focus.

Hall and Fincham (2005) contend that shame can lead to self-destructive reactions and does not predict conciliatory behaviours (Fisher & Exline 2006). To reach self-forgiveness, it is important to work through the self-focused emotion of shame. This will allow the other-focused emotion of guilt/remorse to become the primary emotion expressed. Remorse may serve a more positive, prosocial function in that it is connected to a likelihood of engaging in conciliatory behaviours towards the injured party (Fisher & Exline 2006; Rangganad & Todorov 2010). As remorse is expressed, the desire for restoration should emerge.

- **Restoration**

Restoration as a component of self-forgiveness comprises involvement in reparative behaviours and a recommitment to the values destroyed by the offense. Cornish and Wade (2015:98) highlight the restorative efforts needed in self-forgiveness, including making reparations to those one has hurt, and identifying ways to change one's behaviours so that they match ideal selves. Apologies to the wronged and attempts to make amends are more common among people who have forgiven themselves than among those who have not forgiven themselves. In their qualitative study on self-forgiveness, Zechmeister and Romero (2002 as cited in Cornish & Wade 2015:98) concluded that engaging in reparative behaviours could be considered as one facet of restoration.

Baker (2008) and Holmgren (1998 as cited in Cornish & Wade 2015:98) describe the importance of addressing the attitudes and behavioural patterns that contributed to the offence. As individuals attend to the factors that contributed to their offence, they will likely identify personal values they violated through that offence.

Part of self-forgiveness involves a recommitment to those values to learn from and move beyond their hurtful actions (Baker 2008; Holmgren 1998). Cornish and Wade (2015:98) conclude that recommitment to values may be a crucial element in genuine, as opposed to pseudo self-forgiveness (Wenzel et al 2012 as cited in Cornish & Wade 2015:98). The authors warn that those who do not engage in these steps run the risk of committing similar offences in the future. The offence will also not be resolved for the transgressor until these patterns are addressed (Holmgren 1998 as cited in Cornish & Wade 2015: 98). Once restorative efforts are made, internal resolution of the offence can be achieved, paving the way for feelings of self-forgiveness.

- **Renewal**

Holmgren (1998) contends that negative emotions following a transgression encourage moral growth and holding onto these feelings and judgements after addressing the offence would serve no functional purpose. Therefore, at this stage, it is appropriate to release negative emotions about the offence. Cornish and Wade (2015:98) highlight

that this does not mean to forget that one acted wrongly or to no longer wish one had acted differently because those can serve as important reminders to avoid similar offences in the future. Instead, it means recognising one's intrinsic worth as a person, setting aside remaining self-punishment, and approaching oneself with compassion, acceptance, respect and kindness (Dillon 2001; Fisher & Exline 2010 as cited in Cornish & Wade 2015:98).

### 6.2.3 Rangganadhan and Todorov (2010:6) proposed model of self-forgiveness

According to Rangganadhan and Todorov (2010:1) shame-proneness and personal distress empathy, emerged as the key personality traits involved in inhibiting self-forgiveness. Conciliatory behaviours such as apologising, making restitution or seeking forgiveness from the victim may ease the offender's guilt and the negative distress they associate with their fault, probably because one is now doing the right thing (Hall & Fincham 2005 as cited in Rangganadhan & Todorov 2010:4) (Figure 6.2).

In this study, the structural equation modelling revealed that the Hall and Fincham (2005) model did not provide an adequate fit to the empirical data until the covariance between shame and guilt was incorporated into the model (Rangganadhan & Todorov 2010:1). Correlational research indicates that self-forgiveness is weakly correlated to forgiveness of others, and in some studies, it is shown to be unrelated to forgiveness of others (Thompson et al 2005 as cited in Rangganadhan & Todorov 2010:2).

#### *6.2.3.1 Explanation of self-forgiveness*

In a study by Thompson et al (2005), using an undergraduate sample, researchers found that self-forgiveness was more strongly related to aspects of mental health than forgiveness of others, with low trait self-forgiveness predictive of higher levels of depression and anxiety (Thompson et al 2005 as cited in Rangganadhan & Todorov 2010:2).

High levels of guilt and shame are expected to make self-forgiveness difficult. According to Rangganadhan and Todorov (2010:3), extensive literature shows that a resolution of the self-conscious emotions of shame and guilt is intimately linked to self-forgiveness. Guilt encompasses tension, remorse, anxiety and regret resulting from negative

evaluation of a specific behaviour and is a barrier to self-forgiveness. This implies that those who are prone to experience guilt in response to an offence are more likely to punish themselves by not engaging in self-forgiveness and thus not allowing themselves to get away with causing an offence (Sterlan 2006 as cited in Rangganadhan & Todorov 2010:3).

Guilt is said to have an adaptive effect on relationships because the remorse and regret of guilt motivate behaviours oriented toward reparative action. The model proposes that conciliatory behaviour will act as a mediator between guilt and self-forgiveness, meaning high guilt-proneness will likely display higher levels of conciliatory behaviour following a transgression, which in turn promotes self-forgiveness by absolving an offender's guilt. According to Hall and Fincham (2005), engaging in conciliatory behaviour is an offence-specific variable. However, some individuals may display such behaviour to a greater extent than others, so that it may be considered an individual difference variable together with proneness to shame and guilt.

Rangganadhan and Todorov (2010:4) argue that guilt may also influence self-forgiveness through its association with empathy. Empathy is a multidimensional construct consisting of separate but related constructs. Several studies reveal that guilt is positively related to the cognitive aspect of empathy (Tangney & Fischer 1995; Leith & Baumeister 1998 as cited in Rangganadhan & Todorov 2010:4). These include perspective taking, which is the ability to place oneself in the shoes of another and comprehend her point of view. It also includes an emphatic concern for another, which involves caring about the welfare of others, to a point of becoming upset over their misfortunes (Davis (1994 as cited in Rangganadhan & Todorov 2010:4). It is suggested that the other-oriented empathic concern caused by guilt may work to prevent self-forgiveness (Zechmeister & Romero 2002; Macaskill, Maltby & Day 2002).

Zechmeister and Romero (2002) observed that people who had not reached self-forgiveness more likely reported guilt, regret and other-focused empathy as compared to people who had forgiven themselves. Therefore, empathy is also expected to act as a mediator in the self-forgiveness process, meaning, high guilt proneness is expected to be positively related to high levels of cognitive empathy which in turn will constrain self-forgiveness, since the more one feels one's victim's pain, the harder it is to self-forgive for inflicting the pain (Rangganadhan & Todorov 2010: 5).

In contrast to guilt, shame entails an extreme and a critical focus on the self, rather than the offensive behaviour, and is more likely to promote self-destructive intentions associated with a failure to forgive the self (Tangney 1991 as cited in Rangganadhan & Todorov 2010:5). Guilt may potentially make way for self-forgiveness by motivating reparative behaviours whereas proneness to shame has been positively associated with a tendency to externalise cause or blame and to self-reported anger, arousal and hostility (Tangney 1990; Tangney, Wagner, Fletcher & Gramzow 1992 as cited in Rangganadhan & Todorov 2010:5). These factors will likely limit the shame-prone individual's efforts to deal effectively with their offence and the consequences for their relationship (Lewis 1987 as cited in Rangganadhan & Todorov 2010:5). Therefore, the model suggests a negative association between shame and self-forgiveness (Hall & Fincham 2005 as cite in Rangganadhan & Todorov 2010:5). Rangganadhan and Todorov (2010:5) suggest looking at other potential variables, which may influence the process of self-forgiveness and that the present model of Hall and Fincham (2005) seems to be lacking. However, this model overlooks the evidence that empathy is linked to both guilt and shame (Hoffman, 1983; Tangney, 1991 as cited in Rangganadhan & Todorov, 2010:5). Hall and Fincham's model overlooks the evidence and proposes only a direct link between shame and self-forgiveness. In doing so, this model fails to acknowledge the potential way that shame and empathy may interact to further inhibit self-forgiveness. Rangganadhan and Todorov (2010:5) argue that previous research by Tangney (1991) has already documented that there is a link between shame-proneness and the inclination for self-oriented personal distress reactions, but no study has ever tested the mediating role of personal distress empathy in self-forgiveness. Personal distress empathy, which is part of the emotional constituent of empathy, entails a negative reaction such as anxiety or discomfort on perceiving cues related to another's distress (Batson 1991). Even though personal distress originates in empathic response to another's suffering, the emerging preoccupation with one's own distress is likely to impede the shame-prone person from doing what might otherwise profit their victim and strengthen the relationship.

In their study, Zechmeister and Romero (2002) found that nearly a third of offenders who did not forgive themselves wrote about their own distress in response to their empathy for their victim's suffering. Therefore, it is expected that high shame-proneness will be positively related to personal distress empathy, which will mediate the ability to

self-forgive. This means that the personal distress reaction will make the process of releasing resentment towards oneself difficult, therefore inhibiting self-forgiveness. Rangganadhan and Todorov (2010:2) tested their new model which differentiated between the different components of empathy and allowed for an additional pathway from shame to personal distress empathy (Figure 6.2) against Hall and Fincham's (2005) model (Figure 6.1).

Rangganadhan and Todorov's (2010:10) study aimed at examining the personality traits and behavioural factors that influence the ability to forgive the self, by testing Hall and Fincham's model against their new model. The study revealed a substantial evidence for the role of shame and the mediating influence of personal distress empathy in inhibiting self-forgiveness. Shame and personal distress, rather than guilt and other-oriented empathy, emerged as the key variables involved in inhibiting self-forgiveness. According to Rangganadhan and Todorov (2010:17), it would appear that the weakness in Hall and Fincham's model was its failure to allow for the covariance between shame and guilt to differentiate between the different components of empathy and to incorporate the path between shame and the affective component of empathy personal distress. Personal distress empathy has been linked to shame (Tangney 1991).

Another important finding of this study is that high-shame proneness predicted a difficulty in forgiving the self, following an interpersonal transgression. The mediating effect of personal distress empathy in inhibiting self-forgiveness is of significance because it suggests that in interpersonal transgression situations, shame-prone people are doubly vulnerable to intense negative affect. Moreover, they are likely to experience the resonant pain of personal distress as well as the pain of shame for being the kind of person who inflict so much harm (Tangney 1991). Such factors would certainly make it difficult for the individual to renounce self-resentment, or develop the self-acceptance necessary for self-forgiveness to take place (Rangganadhan & Todorov 2010:18).

Other findings of the study were that there was no evidence that those who were more religious were also more self-forgiving. Regarding gender effects, there were no significant differences found between men and women on self-forgiveness, but on the measures of shame, guilt, empathic concern, personal distress, empathy, and

conciliatory behaviour, female participants in the study scored higher than male participants (Rangganadhan & Todorov 2010:11).

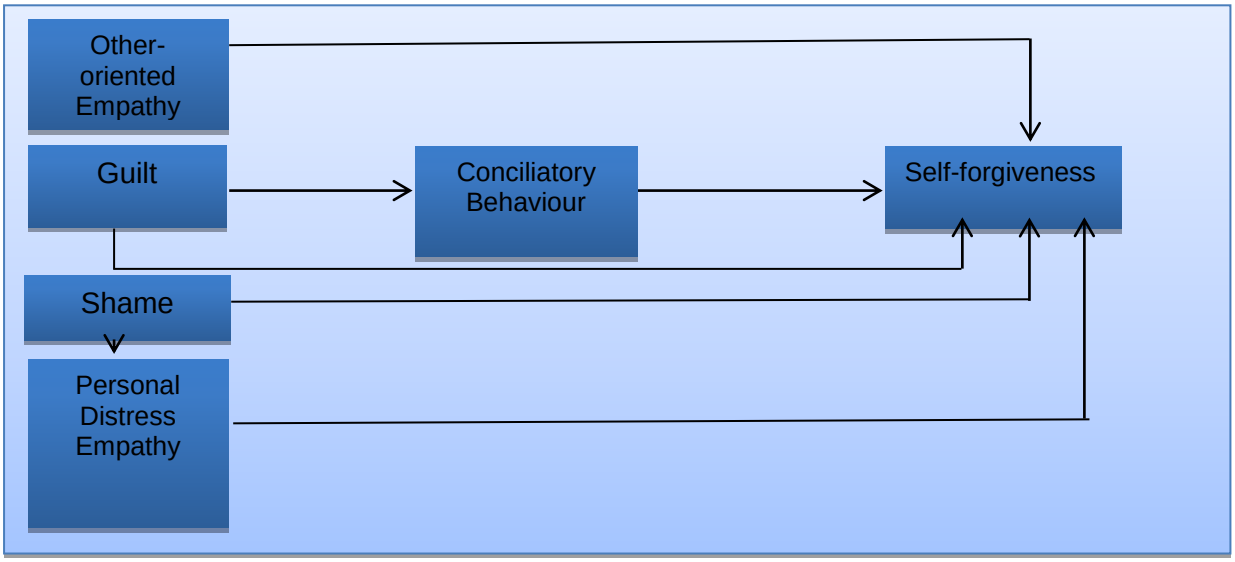



**Figure 6.2 Rangganadhan and Todorov's model of self-forgiveness**

(Rangganadhan & Todorov 2010:6)

### 6.2.4 The social ecological model (Grabbe et al 2016:240)

The Social Ecological Model (SEM) (Figure 1.1) has been described in Chapter 1, 1.7 of this study. Prevention of mental ill-health after TOP is important and counsellors are in a position to be involved in primary prevention, before any mental ill-health has set in after TOP; secondary prevention (that is, case finding and interventions to interrupt the development of sequelae of guilt, shame, aggression and regret after TOP) and tertiary prevention that is instituted when the sequelae has occurred. The Social Ecological Model for Self-forgiveness, with its four levels- individual, relationship, community and society- is used in this study for understanding and identifying targets for health behaviour interventions (Golden et al 2015:11) and for prompting ways to effect health change at each level or concurrently across various levels.

For the Model of Self-forgiveness to explain the experiences of women who terminated pregnancy and change in their mental health, it must take into consideration the internal and external influences on these women, as well as the different levels of influence, including the individual level, relationships level, community level and societal level.

Following this model, factors that influence the behaviour of women after TOP at each level are identified in Figure 1.1. These factors form points at which counsellors and the human service systems can play a role to improve mental health after TOP because adolescents who terminated pregnancy appear in all human service systems as clients (Grabbe et al 2016: 239). These SEM will come useful in psychoeducation as well, to see the importance of including a significant other for support of the woman after TOP.

## 6.3 DEVELOPMENT OF A MODEL OF SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY DURING ADOLESCENCE

The major findings of this study informed the model development together with the support of literature. Of importance is that the development was underpinned by the Social Ecological Model.

### 6.3.1 Core concepts

The core constructs of this conceptualised model are :

- Self-condemnation and self-blame.
- Cultural and spiritual constructs.
- Reproductive coercion

This study highlighted the following experiences in relation to the SEM:

- **Young adult woman**: Experience of self-condemnation and self-blame, leading to shame and guilt about TOP. The shame and guilt stemmed from their cultural and spiritual beliefs about TOP and for some participants it could be stemming from their personality trait of ruminating about problems or being shame or guilt prone.
- **Relationships, community and society**: The women's cultural beliefs and religion impacted on their emotional experiences of guilt and shame stemming from self-blame and self-condemnation. The fear of being stigmatised and judged by those she is in close relationship with, like family, the partner, the church, the community and through societal norms about TOP was mostly at the root of this experience.
- **Relationships**: Reproductive coercion from male partners may influence the adolescent's unplanned pregnancy and pregnancy outcome as well as their

decision-making about the resolution of their pregnancies. Societal gender roles related to dependence of some women on their partners for material goods and income can lead to male dominance and reproductive coercion.

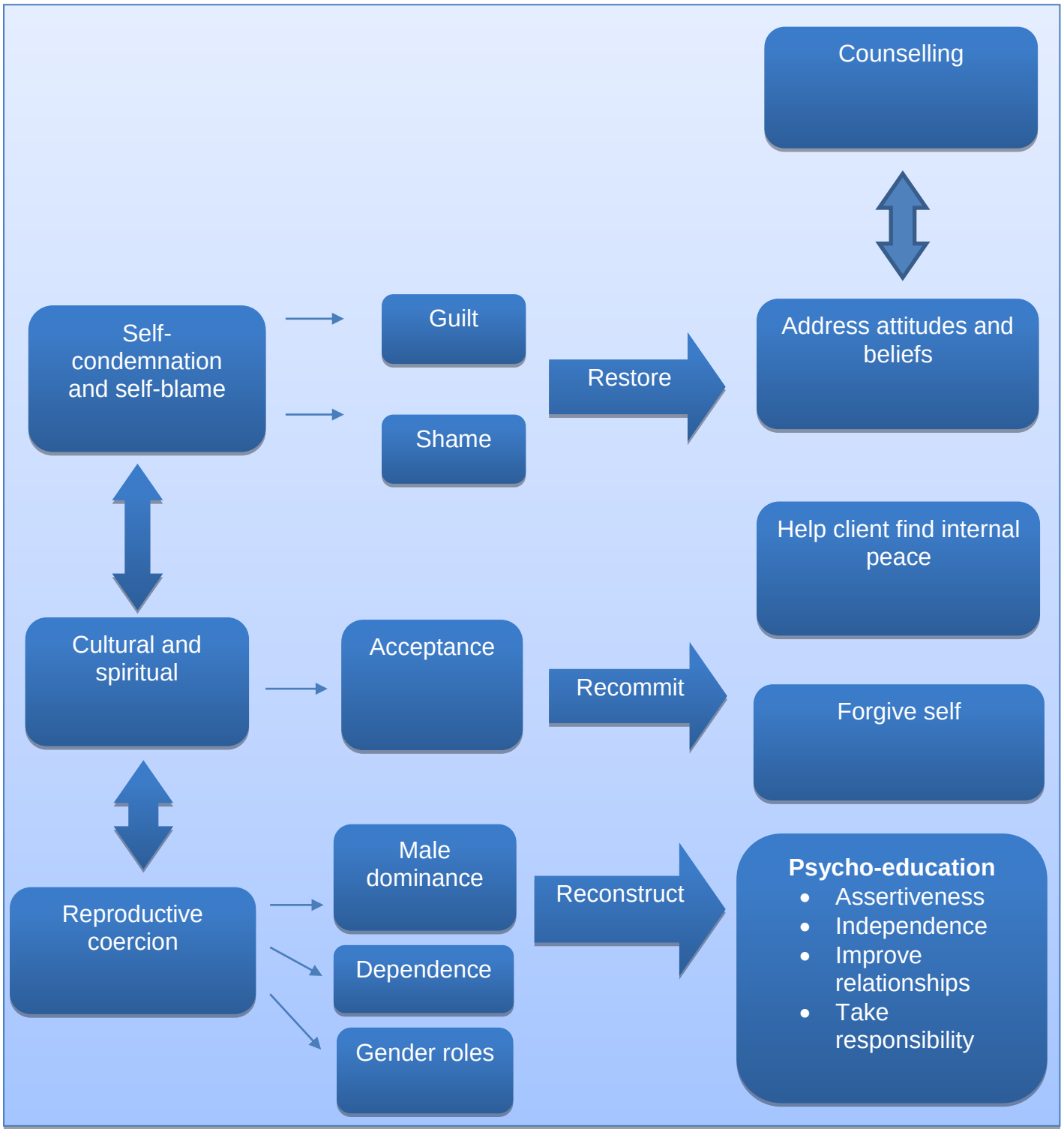



**Figure 6.3 Model of self-forgiveness for women who terminated pregnancy during adolescence**

### 6.3.2 Self-condemnation and self-blame

Individual women experienced self-condemnation and self-blame which are linked with indicators of psychological distress, shame and guilt (Fisher & Exline 2006 as cited in Fisher & Exline 2010:551), and with less movement toward self-forgiveness (Fisher and Exline 2010:551). On its own, self-condemnation, more so than remorse, is associated with poor psychological well-being. Post TOP, women experiencing shame could get caught up in self-condemning responses. According to Fisher and Exline (2006:141), self-condemnation reflects a more global, negative and severe stance towards oneself. Self-forgiveness requires that people stop condemning themselves.

Women who struggle to release negative feelings about having terminated their pregnancy may benefit from working through shame, accepting human limitations and human weakness. For instance, this could be achieved by acknowledging that one could not have known the extent of the negative emotional consequences that would occur from TOP. Through accepting responsibility for the wrong, remorse, restoration and renewal, women who terminated pregnancy can move on from self-condemnation toward a sense of self-forgiveness and self-acceptance (Cornish & Wade 2015:93).

#### *6.3.2.1 Guilt*

Guilt is explained as negative feelings focused on a specific transgression and its effects on others (Tangney & Dearing 2002 as cited in Fisher & Exline 2010:553). Guilt is an other-oriented emotion that is linked to empathic and prosocial behaviour (Leith & Baumeister 1998; Tangney & Dearing 2002 cited in Fisher & Exline 2010:553). It is linked to feelings of remorse, which in turn are associated with repentance, willingness to accept responsibility for the offence and humbling character changes in the wake of an offense (Fisher & Exline 2006:553).

- **Restoring: Resolving guilt**

According to Fisher and Exline (2010:553), reparative behaviour to resolve guilt has power. For the present study, reparative behaviours that helped participants to cope with guilt involved asking forgiveness from God through prayer and from the victim, that

is, the aborted baby, through confessions. Participants found it easier to forgive themselves once they perceived forgiveness from both God and the victim, which in this study is the aborted baby.

Other reparative behaviours were related to the aborted baby, where, through confessions, the mother offered a sincere apology to the aborted baby and asked for forgiveness from the aborted baby. Participants who believed in the sanctity of life felt that their guilt would be resolved if the foetus was buried with dignity because it was a live human being. Fisher (2008 as cited in Fisher & Exline 2010:553) note that people engaged in relationship-mending behaviours of confessing, admitting blame and making amends reported increased self-forgiveness.

Cultural practices related to death rituals involved the women undertaking body and blood cleansing, by washing with herbs and drinking water and herbal teas that have been prayed for by their church pastors or church prophets. This was done to cleanse their body and blood so that they would be capable of conceiving in the future. The findings suggest that reparative behaviours can be an effective means of resolving guilt. Behaviour patterns that led to the offense should also be addressed and the values violated by the offense should be reaffirmed.

Remorse will prompt reparative behaviours and knowledge of having repaired the damage and undertaken the necessary rituals and ceremonies will reduce guilt (and shame as well). As part of counselling, health professionals are encouraged to discuss cultural rituals and participants' feelings about them. If one feels guilty about TOP, one can alleviate the guilt through reparations and amends, but if one feels shame, it is difficult to make up for a global sense of being a bad person.

- **Resolving excessive guilt when relational repair is impossible**

In situations like TOP where the foetus died, the damage cannot be reversed. In the case of TOP the life of the baby/foetus has been permanently terminated and in such situations high levels of guilt and remorse can backfire and become oppressive.

In such a situation, some women may resort to self-punishment, for example, rumination (Mash & Wolfe 2016:141) when they feel that their reparative attempts are

not adequate. However, self-punishment provides diminutive relief from guilt, if any. On the contrary, as cited by Fisher and Exline (2010:554), Richards (1999) asserts that those who commit self-punishment might get a sense of pride and control by holding themselves up to a high moral standard. However, self-punishment alone may deepen shame because it only focuses on the transgression while ignoring the more useful alternatives like the solution to the problem, repentance and growth (Fisher & Exline 2010:554).

As cited by Fisher and Exline (2010:554), Holmgren (1998) indicates that another problem with self-punishment is that if the individual feels that the atonement is insufficient, the self-punishment will be perpetuated. In contrast is the Catholic concept of confession and penance, where people confess their sins to a priest; the priest instructs them to recite prayer a certain number of times in penance. The concept represents one where once the acts of confession and penance are completed, one should start having relief from guilt; the transgressor begins to focus on reparations instead of the transgression, and there is a specified end point.

When guilt has become excessive or chronic, it no longer serves any useful value. As stated by (Fisher & Exline 2010:554), the counsellor may advice the woman to benefit self-forgiveness by “letting go” of guilt feelings, thereby allowing themselves to release the pain caused by shame and guilt. Even in the absence of guilt and shame, people may experience lingering negative emotions related to TOP, which could be related to regret.

- **Regret**

Regret can act as an obstacle to self-forgiveness. As cited by Fisher and Exline (2010:555), Lucas (2004) describes regret as a wish to return to the past and change a decision. Central to regret is the cognitive process of comparing the effects of an actual decision with an alternate, imaginary outcome. Regret involves imagining how a situation could have turned out differently if another choice had been made. In cases where people harm themselves alone, regret may be the predominant negative emotion. Some scholars feel that self-forgiveness can be relevant in individual cases, those in which actions or inactions of an individual caused harm to self, and not to

others (Enright and The Human Development Study Group 1996 as cited in Fisher & Exline 2010:555).

- **Resolving regret: Forgiving self**

Where people show high levels of regret, there is a tendency to overestimate the validity of different choices or the amount of control they had over outcomes of the situations they were in.

Counsellors need to know the following in order to resolve regret:

- It is essential to reduce the belief of certainty that the alternative choice was better or truly possible (van Dijk & Zeelenberg 2005 as cited by Fisher & Exline 2010:555).
- It is important to identify the individual's values and compare them against the individual's behaviour. When a person behaves in a manner that is inconsistent with his/her values, he/she will have regrets, whether the result of the decision is positive or negative (Pieters & Zeelenberg 2005, as cited by Fisher & Exline 2010:555).
- In such cases where the individual cannot resolve regret by reducing expectations of alternative choices, or identifying discrepancies in behaviour and values, the same principles of "letting go" of regret will have to be followed (Fisher & Exline 2010:556).
- As cited by Fisher and Exline (2010:555), Bowman (2005) suggests that there are cases where people feel they lost a part of themselves. In these cases, they may have to be allowed to grieve the loss of a valued identity, for instance, having terminated a pregnancy, or lost opportunities, in order to make peace with themselves.
- People who are experiencing regret might benefit from accepting their human limitations.
- Lim and Tan (2001) suggests resolving regret by shifting focus from imaginary outcomes to present reality of available options, for example, on self-forgiveness, rather than on those that no longer exist.

- Regret easily arises for those who continue to meditate about lost opportunities and are unable to find closure (Beike, Markman & Karadogan 2009 as cited in Fisher & Exline 2010:555).
- Where all the above suggested strategies fail to resolve regret, emotional release (letting go), that is used to resolve guilt might help.
- Where regret involves a sense of loss of identity, the person may need to grieve the loss of a valued identity that existed before TOP, in order to find a sense of peace and self-forgiveness (Bowman 2005 as cited in Fisher & Exline 2010:555).

#### *6.3.2.2 Shame*

Shame is a negative feeling focused on the whole self. It is an intensely unpleasant emotion, one that involves negative emotion directed at the whole self (Tangney & Dearing 2002). People experiencing shame often report self-condemnation, feeling inferior, worthless, and powerless, together with a sense of feeling exposed and wanting to hide (Fisher & Exline 2010:551).

In the present study, women who terminated pregnancy experienced TOP as murder or killing of their innocent babies, therefore as an offence. Over and above, they felt that they offended or sinned against a Higher Being, that is, God, and therefore deserved God's punishment. They referred to themselves as murderers, meaning they experienced shame about TOP.

Owing to the distressing nature of shame, people experiencing shame often become more concerned with finding emotional relief than with empathising or mending relational harm. In the case of this study, this refers to a relational harm with God and with the baby they aborted, depending on their cultural beliefs. In seeking relief, they may hide their offences, avoid contact with those they harmed (which is God in this study), exaggerate circumstances surrounding TOP, omit facts that cast them in a negative light, justify their actions, supress emotions, excuse their actions or blaming others (Stillwell & Baumeister 1997 as cited in Fisher & Exline 2010:551). Women with shame-based dispositions have characteristics that would impede genuine self-forgiveness, such as impaired perspective taking (Tangney & Dearing 2002 as cited in Fisher and Exline 2010: 551), tendency to blame others and being defensive, rather than offering reparations or learning from their mistakes.

Shame makes self-forgiveness more difficult as the person experiencing it focuses more on the distress that the situation caused her rather than its effect on the victim or on the relationship with a Higher Being (Fisher & Exline 2010:551). Shame is therefore an obstacle to self-forgiveness because of its global devaluation of self. Brief shame experiences could have value as motivators, assuming that they are quickly channelled in prosocial directions (Fisher & Exline 2010:551).

- **Restoring: Resolving shame**

In restoration, development of empathy towards self, while working to reduce the shame-based identity as a murderer, should be emphasised. Women who terminated pregnancy and consequently experience shame should be taught to distinguish between themselves and their actions, learning to accept that doing bad things does not necessarily mark them as bad people, that is, as murderers (Braithewaite, 2000 as cited in Fisher & Exline 2010:551). This will more likely enable those who manage to make such a distinction to abstain from future hurtful actions. According to Tangney and Stuewig (2004 as cited in Fisher & Exline 2010:552), educating people about the difference between shame and guilt may help to reduce shame while also offering them the hope of being good persons and the possibility of a positive change.

In an internet-based self-forgiveness intervention (Fisher 2008, as cited in Fisher and Exline 2010:552), in which one component encouraged participants to reflect on the difference between bad behaviour and being a bad person, participants reported less self-punishing attitudes after the exercise.

Rowe and Halling (1998 as cited in Fisher & Exline 2010:552) discovered in their study that some people fluctuated between self-acceptance and self-condemnation of themselves while working towards self-forgiveness. However, many ultimately came to a point of self-acceptance, many became more aware that flaws are an inherent part of human nature and experienced feelings of connectedness to all human experiences. As self-forgiveness increased, participants were able to continue acknowledging negative feelings while being able to prevent those feelings from permeating every aspect of their lives.

Bowman (2005 as cited in Fisher & Exline 2010:551) also produced similar findings that people in a self-forgiveness process often reached self-acceptance while retaining their sense of responsibility for the wrongdoing. An important goal of the self-forgiveness process for women who terminated pregnancy during adolescence is to reduce shame so that these women can face their personal limitations while still seeing themselves in a positive light. Yet, because negative emotions might be necessary to enhance repentance, it might be wrong to encourage them to simply rid themselves of all negative feelings about their TOP – especially because TOP is a serious life event (Fisher & Exline 2010:553).

The counsellor may have clients write letters to themselves that acknowledge internal pain and the reasons they are so angry at themselves (Greenberg 2002 as cited in Cornish & Wade 2015:99). The author also suggests using an emotion-focused two-chair work (with the client's self-condemning side and the side that believes he or she is worth forgiving) in which the client works through negative feelings, may also help reduce shame as through this work the client will realise that self-punishment is not working.

By the client gaining a better understanding of the reasons behind their shame and self-punishment, clients may realise that they need to re-evaluate their expectation for themselves (Worthington 2006 as cited in Cornish & Wade 2015:99), and they may accept their inherent values despite the wrong they committed.

When shame is properly reduced, clients are left with feelings of guilt about the TOP. The counsellor can now explore this feeling of guilt with the client. This exploration can result in the desire to make things right and clients can also gain a better understanding of how they violated their personal values through TOP and can begin to identify how they want to make things right again (Cornish & Wade 2015:99).

#### *6.3.2.3 Address attitudes and beliefs*

During counselling, it is importance to address the attitudes (Baker 2008 and Holmgren 1998) as cited in Cornish and Wade (2015:98), and beliefs that contributed to TOP. As women address the attitudes and beliefs that contributed to their TOP during adolescence, they will likely identify personal values they violated through that offence.

Part of self-forgiveness, then, involves a recommitment to those values to learn from and move beyond their hurtful actions. This recommitment to values may be an important component of genuine self-forgiveness (Wenzel et al 2012 as cited in Cornish & Wade 2015:98). Those who do not address these attitudes and beliefs may be at risk of committing similar offences in the future. On the contrary, offence will also not be resolved for the transgressor until these attitudes and beliefs are addressed.

## 6.4 CULTURAL AND SPIRITUAL FACTORS

### 6.4.1 Cultural

Culture refers to the widely shared customs, beliefs, values, norms, institutions, and other products of a community that are transmitted socially across generations. Weiten (2013:25) alludes that even the understanding of life, power as well as gender relations are an expression of culture. Every group of people is identified through its culture.

In the Black culture, a woman who cannot bear children is belittled. In the present study, the participant's fear of not being able to conceive in the future was probably escalated by the guilt of having murdered their babies, and most participants felt it was one of the punishments they deserved. Therefore, Turyomumazima (2017:2) explains that a child is thought to be a re-incarnation of the departed, so a woman without children stops her line of physical continuation.

As almost all participants were Black women, fertility is culturally very important for their mental well-being and acceptance in their communities. Cleansing their bodies would enable them to conceive in the future, according to their belief, because abortion made their blood "dirty". According to Black culture, even death of a foetus is associated with misfortune in all areas of one's life's (Conversation with a traditional leader, 25th August 2016).

This is why even after TOP, some participants needed their bodies and their "*blood*" to be cleansed by drinking and bathing with traditional herbs, drink special tea or special water that has been prayed for by their church "prophets" or pastors. Despite a larger percentage of indigenous population being converts to Christianity, there are still

indigenous beliefs and values, which mainly serve to facilitate their religious and cultural expression.

Many participants expressed fearing that God will judge them negatively as they murdered their babies. It is within this cultural belief system that TOP brings about guilt and shame as participants feel they have transgressed from normal cultural practice. Eventually, shame can further lead to self-condemnation and self-blame (Cornish & Wade 2015:99).

### 6.4.2 Spiritual

The majority of the participants were Christians. Religious ideology and practices have established male-dominance in decision-making and attitudes about reproduction (Moloko-Phiri 2015:158). In traditional Africa, children are highly valued in society and are regarded as precious. Marriage and procreation in Africa are a unity and therefore, until a wife has given birth, marriage is incomplete (Turyomumazima 2017:1). The Holy Scriptures and church tradition emphasise the sacredness of life and the dignity of every human being. Therefore, as Turyomumazima (2017:1) notes, Christianity condemns TOP. Owing to their Christian religion, they regarded TOP as sin of murder.

For the adolescents, spirituality plays an important role in death and loss and so for them losing a pregnancy through TOP provoked questions about values as well as the meaning of life and death (Curley & Johnston 2014). Almost all participants interviewed expressed that they feared God's punishment or God rejecting them at the time of their death. The experience of guilt therefore brought them closer to God through prayer for forgiveness, attending church and studying the Bible. People with heartfelt religious convictions, according to Abdel-Khalek (2006 as cited in Weiten 2013:406), are likely more happier than people who are non-religious.

Myers (1992 as cited in Weiten 2013:406) noted that religion can give people a sense of purpose and meaning about their experiences in their lives. Some women expressed having a relationship with God and were not feeling hopeless about self-forgiveness and forgiveness from God. Most participants feared God's punishment for their sin of TOP. Some believed that after God has forgiven them, they would be able to forgive themselves. Self-forgiveness is about accepting one's flaws and religion helps people to

accept their setbacks gracefully (Weiten 2013:406). Remaining in the church community could help these women to connect to caring and supportive people within the church (Weiten 2013:406). From the study findings, a significant number of participants (10) reported that they were not ready to go back to church because the church discriminated against them. This attitude from the church community left them feeling guilty and rejected.

Zechmeister and Romero (2002 as cited in Hall & Fincham 2008:180) argue that spirituality is uniquely and distinctly related to self-forgiveness and therefore greater perceived forgiveness from a Higher Power will be associated with higher levels of self-forgiveness. Cafaro and Exline (2003 as cited in Hall & Fincham 2008:181) support this idea from a study that found that self-forgiveness was positively associated with believing that God had forgiven the self for a transgression. Subsequently, this increases in perceived forgiveness from a Higher Power within individuals and from the victim will be strongly linked to increases in self-forgiveness.

#### *6.4.2.1 Acceptance*

The process of self-forgiveness is complex, especially in cases of serious harm like TOP. The emotions of guilt and shame which usually accompany TOP can be painful, therefore tempting some people to take shortcuts by not accepting responsibility for wrongdoing. This will inhibit genuine self-forgiveness and personal growth, among others. Fisher (2008 as cited in Fisher & Exline 2010:553) asserts that people engaged in relationship- mending behaviours of confessing, admitting blame and making amends reported increased self-forgiveness.

#### *6.4.2.2 Recommitting*

To recommit is to yet again, make it impossible for oneself not to do something or to do something else, that was not promised or not pledged (Hornby 1989:231). According to Cornish and Wade (2015:98), recommitment to the values damaged by the decision to terminate the pregnancy leads to restoration. Making reparations to those hurt by the offense and identifying ways to change their behaviour to better match their ideal selves are important for recommitting. To make reparations, some participants in the present study decided to apologise to the aborted baby by confessing their perceived wrong of

TOP to the aborted baby, while one participant expressed the wish to could have buried the aborted baby in a dignified manner instead of just discarding it with other products of conception. Such practices increase self-forgiveness (Exline, Root, Yadavalli, Martin & Fisher 2011). Forgiving the self and helping the client find internal peace need to be addressed during counselling.

#### *6.4.2.3 Help client find internal peace*

According to Rowe and Halling (1998 as cited in Fisher & Exline 2010:552), as women who terminated pregnancy work towards self-forgiveness:

- They need to come to a point of self-acceptance and be aware that flaws are an inherent part of human nature.
- They need to feel connected to all human experiences themselves.
- They need to continue acknowledging negative feelings while being able to prevent those feelings from permeating every aspect of their lives.
- They need to retain their sense of responsibility for wrongdoing.
- They need to understand and reduce shame so that they can face their personal limitations while still seeing themselves in an optimistic light.
- They need to realise that negative emotions are necessary to fuel repentance.

#### *6.4.2.4 Forgive self*

According to the therapeutic model of Cornish and Wade (2015:93), encouraging renewal through recommitting is the final component of self-forgiveness. It involves a renewed self-image, which incorporates the past and gives direction to the future.

As stated by Holmgren (1998 as cited in Cornish & Wade 2015:98), negative emotions and self-condemnation encourage moral growth over time. After addressing the wrong of terminating a pregnancy (according to the woman's perception), holding on to guilt, shame, regret and personal distress empathy would serve no purpose. At this stage, it is fitting to release lingering negative emotions about TOP. However, this does not mean to forget that one acted wrongly or to no longer wish one had acted differently, because those can serve as important reminders to avoid similar offences in the future

(Dillon 2001 as cited in Cornish & Wade 2015:98). The counsellor should emphasise to the client that it actually entails recognising one's intrinsic worth as a person, setting aside remaining self-punishment and approaching oneself with compassion, acceptance, respect and kindness (Dillon 2001; Fisher & Exline 2010 as cited in Cornish & Wade 2015:98).

To achieve renewal, women who find it difficult to release negative feelings about TOP may benefit from being encouraged by the counsellor to accept human limitations and weakness by acknowledging that one could not have known the extent of the negative consequences that would occur from their TOP (Fisher & Exline 2010 as cited in Cornish & Wade 2015:93).

They can also be encouraged to acknowledge their recommitment to major values (for example, never to fall prey to unplanned pregnancy), even while recognising the difficulty of always living up to those values (Cornish & Wade 2015:93). More importantly, counsellors could help these women to re-narrate about TOP, by focusing on the lessons learnt and the positive changes the women have implemented throughout the self-forgiveness process. The counsellor may instruct the woman to write a letter about self-forgiveness as homework.

### 6.4.3 Reproductive coercion

Reproductive coercion was one of the major findings of the study. Male partner reproductive coercion (RC) is explained as male partner attempts to promote pregnancy in their female partners through verbal pressure, threats, and coercion related to pregnancy continuation or termination (Miller & Silverman 2010:511).

According to United Nations, Department of Economic and Social Affairs, Population Division (2013 as cited in Santhya & Jejeeboy 2015:191), in 2013, there were 580 million adolescent girls in the world. An overwhelming majority (88%) lived in the low-income and middle-income countries and many of these girls are denied the right to make safe and informed decisions that affect their health and well-being. This situation has implications for their later health and the health of the next generation. According to the model, reproductive coercion was influenced by cultural practices and religious

beliefs. In turn, reproductive coercion may be associated with male dominance, dependence of women on the partner or gender roles.

#### *6.4.3.1 Male dominance*

Reproductive coercion by itself involves the exertion of power and control, commonly by a male over the female partner (Park et al 2016:74). According to Park et al (2016:75), female adolescent are more susceptible to abuse than their adult counterparts, with most of these girls reporting that they were unable to discuss condom use with their partner because of fear of physical or emotional abuse.

Violence against girls takes many forms, including IPV, trafficking, among others, and it is mainly perpetrated by partners or husbands, reflecting in-egalitarian gender norms (Santhya & Jejeebhoy 2015:193). For many girls, sexual initiation, before or within marriage, is forced or coerced. A global review shows that such women are more than twice as likely to have an induced abortion, are more than twice as likely to experience depression.

#### *6.4.3.2 Dependence*

The likelihood of IPV increases during pregnancy. According to Lowdermilk et al (2016:102), poor and uneducated women tend to be disproportionately represented in abuse because they are financially dependent on their partners, have fewer resources and support systems, and may have fewer problem solving skills. In the present study, the majority of participants, that is, 21, had secondary education as the highest level and five had tertiary education. The rest, that is four, had primary education as the highest level of education.

#### *6.4.3.3 Gender roles*

Women generally value their social roles and this may have an influence in IPV. Traditional feminine characteristics such as compassion, sympathy, and yielding often results in greater tolerance of male dominance and more acceptance of partner violence. In contrast, the qualities of assertiveness, independence, and willingness to take a stand have been viewed as characteristic in women who are in non-violent

relationships (Faramarzi, Esmailzadeh, & Mosavi 2005 as cited in Lowdermilk et al 2016:102). Girls commonly do not have the negotiating skills or power to refuse unwanted or unsafe sexual relations and many are raised not to confront someone with whom they disagree (Santhya, Jejeebhoy, Saeed & Sakar 2013).

Early and forced early marriages (before the age 15 or 18) and unmet needs are often found among adolescents residing in rural areas, with limited education and belonging to economically disadvantaged households or socially excluded ethnic groups. Those girls who were married early were less likely to have been consulted on the timing of marriage and the choice of spouse, as well as the opportunity to have had an opportunity to get to know their spouse before marriage (Santhya & Jejeebhoy 2015:196).

Believing that being pregnant protects a woman from IPV is a myth as 4% to 8% of all women experience violence during pregnancy (Lowdermilk et al 2016:103). It is also reported more frequently in lower-class families although it can be reported in any family. High rates of unintended pregnancy observed among adolescents are frequently associated with early marriage and experience of violence (Santhya & Jejeebhoy 2015:194).

#### *6.4.3.4 Reconstruct: Psychoeducation*

Psychoeducation should be part of counselling of women before and after TOP. Within the counselling context, psychoeducation about the differences between shame and guilt may help clients reduce their internal, global attributions about TOP, hence reduce shame. Helping clients make a difference between themselves and their actions may send a message that bad actions do not necessitate an identity as a bad person (Braithwaite 2000 as cited in Cornish & Wade 2015:99). Shame may also be reduced through the development of skills to approach oneself with self-compassion, which would allow these women to examine their faults without descending into shame (Fisher & Exline 2010). The expression of unconditional personal regard by the counsellor may help to improve the client's self-worth. Clients can also be helped to realise that all people are imperfect (Jacinto & Edwards 2011), and that self-punishment is not a beneficial response to wrongdoing.

The counsellor should explain in simple terms and teach women how to attain the following:

- Assertiveness, independence, decisions on whom and when to marry.
- Willingness to take responsibility on matters that affect the woman and her children.
- Believing that being pregnant protects a woman from IPV is a myth. A woman should take responsibility of her life. 4% to 8% of all women who experience violence experience it during pregnancy (Lowdermilk et al 2016:103). It is also reported more frequently in lower-class families although it can be reported in any family.
- Improve relationships with husband or partner, with family members, with social networks, within the community organisations. Strengthening peer support is important as well as group solidarity.
- Increasing awareness of reproductive coercion and IPV and their impact on women as well as gender equality and critical thinking. This should be done at individual level, at organisational level, at community and societal levels.
- Training and education of those in positions to screen and identify at-risk women, for example, health care workers, social workers, teachers, youth organisations, amongst others.
- School-based and community-based education on health and gender norms and roles, to reduce violence
- Inform the woman about their bodies, comprehensive sexuality, health-promoting behaviours, power, contraception, economic empowerment, financial literacy, and saving as well as self-protection planning.

## 6.5 CONCLUSION

A model of self-forgiveness for women who terminated pregnancy during adolescence was developed and discussed in this chapter. Given the interpersonal and intrapersonal benefits associated with self-forgiveness, it is encouraged that health personnel should consider self-forgiveness as a goal for women who struggle with the negative emotional consequences of TOP.

The therapeutic model of self-forgiveness stressed the components of responsibility for an offence, remorse about the wrongdoing, restoration that leads to renewal of self-respect, self-compassion, and self-acceptance (Cornish & Wade 2015). Acceptance of responsibility for TOP may cause a woman to realise her imperfections and accept that she should have done things differently and this could lead to remorse, shame and guilt, which the counsellor will assist the woman to work through.

Rangganadhan and Todorov's (2010) self-forgiveness model was based on the Hall and Fincham's model (2005) and it aimed at examining the personality traits and behavioural factors that influence the ability to forgive the self. provided evidence for the role of shame and the mediating influence of personal distress empathy in inhibiting self-forgiveness. Rangganadhan and Todorov's (2010:5) self-forgiveness model acknowledges the potential way in which shame and empathy may interact to further inhibit self-forgiveness. For this study, their model highlights that shame-prone women who are inclined to self-oriented personal distress responses after TOP, will be impeded from forgiving themselves. There is therefore a need for counsellors to explore the experience of shame and preoccupation with personal distress during counselling of women after TOP. Exploration will enable the woman to express feelings of shame and the accompanying distress, enabling the woman to verbalise what she wishes should be done in order for her to find closure.

The Hall and Fincham's Model (2008) revealed that self-forgiveness increased linearly over time. Decrease in guilt and perceived transgression severity as well as conciliatory behaviour toward a Higher Power were associated with an increase in self-forgiveness. An increase in perceived forgiveness from the victim (an aborted foetus) and a Higher Power, were also related to an increase in self-forgiveness. The model of the present study added the importance of the role played by cultural practices and religion in helping women who terminated pregnancy to self-forgive.

# CHAPTER 7

# GENERAL SUMMARY, JUSTIFICATION, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION

## 7.1 INTRODUCTION

The previous chapter focused on the development of a model of self-forgiveness for women who terminated pregnancy during adolescence. This chapter presents the justification of the study in relation to its purpose and objectives, the general summary, the recommendations, suggestions for future research, the limitations of the study as well as the unique contributions made by the study.

## 7.2 GENERAL SUMMARY OF THE STUDY

The study was conducted among women aged 20 to 35 years who terminated pregnancy in adolescence. The study was conducted at a Health Care Centre in Tshwane Municipality of the Gauteng Province, in South Africa. It was conducted in three phases. Phase 1 covered the desktop review, which focused on understanding what is already known in literature about the topic. For the desktop review, 38 articles which included monograms, policy documents, past thesis and published articles were read, and covered topics on reproductive coercion, guilt and self-forgiveness, as well as TOP in adolescence.

Phase 2 covered the lived experiences of participants about TOP. In this phase, individual, semi-structured, in-depth interviews were used to enable the personal narrative to emerge. To ask the right questions required, a self-developed interview guide consisting of broad questions (Watson, Benner & Ketefian 2008:335) was used.

Participants narrated their experiences about TOP. The researcher, through narratives, sought to understand the meanings that participants ascribed to their experiences about TOP. This was done in order to comprehend how women make sense of their TOP, that is, to understand how participants express the reality of what actually happened during TOP and how they experienced what happened and how they relate their story to reflect

on the experience from their own point of view (Sandelowski 1991:161). Both the participant and the researcher derived meanings related to the experience (Polit & Beck 2014:274).

Lastly, in phase 3, a self-forgiveness model for women who terminated pregnancy during adolescence was developed. The model aimed at assisting professionals who are involved in counselling women who terminated pregnancy to improve their counselling services. The model was informed by the findings from phase 1 and phase 2. It is recommended that this model should be part of the counselling protocol of women before and after TOP, part of the nurse training and education curriculum for SRH, basic nursing diploma and degree courses.

## 7.3 JUSTIFICATION

The study is justified in relation to its purpose and objectives. The purpose of this study was to explore self-forgiveness for women who terminated pregnancy during adolescence. Several studies have revealed that TOP is related to negative emotions of guilt and shame, among others. Most studies on TOP have not considered the inclusion of self-forgiveness as part of counselling, despite its alluded usefulness in addressing the negative emotions of guilt and shame, which may be associated with TOP. Despite its limitations, this study has addressed this gap by developing a model of self-forgiveness to guide counselling of women after TOP.

There is a need for self-forgiveness to assist women who are burdened with guilt and shame in order to release these negative emotions for psychological well-being. To this end, a model was developed for use during counselling of women who terminated pregnancy during adolescence. Therefore, the study is justified as its purpose and objectives have been met.

To the researcher's knowledge, this study is the first of its kind in South Africa. Developing a model of self-forgiveness for women who terminated pregnancy in the South African context will be beneficial for use even in the whole sub-Saharan Africa as most countries in this region share similarities in culture and religious understanding. The purpose of this chapter is to illustrate how findings were used to propose recommendations and highlight unexpected but significant outcomes. The study aims to

empower and capacitate counsellors of women who terminated pregnancy to better counsel and support these women, and subsequently facilitate the healing process.

## 7.4 OVERVIEW AND SUMMARY OF THE RESEARCH FINDINGS

The present study explored and interpreted the meaning of TOP among 30 women, 20 to 35 years old, who terminated their pregnancy during adolescence. The goal was to develop a model of self-forgiveness for use during counselling.

The following are the main research findings:

**Central theme**: Women who terminated pregnancy in adolescence find a way towards forgiveness through forgiving self by having a relationship with God and prayer.
From the data collected, different themes and sub-themes were identified.

The major findings were as follows:

### 7.4.1 Theme 1: Transgressing one of nature's strongest instincts: The mother's protection of her young

From this theme, more subthemes were identified. It became clear from the sub-themes that participants experienced regret, guilt and shame about TOP. The guilt was related to having killed their innocent babies. The guilt and shame were related to their religious beliefs that TOP is murder and they felt they wronged a Higher Being, that is, God. Some referred to themselves as murderers. Part of the guilt was related to the fear of not conceiving in the future. Most participants interpreted this as a punishment from God for the sin of TOP.

All participants indicated that factors such as immaturity, parental or peer attitude, the church, education, and employment prospects were more important than moral considerations at the time when they were deciding about TOP. Although the moral picture changed after TOP, participants still felt that they violated their moral standard by killing their own unborn babies instead of protecting them.

Studies conducted with women under the age of 21 (Lie, Robson & May 2008:3) revealed similar findings that the woman's value system and her social norms from the society, the church and the community weakened, as a woman was engaged in deciding to terminate a pregnancy. Socially, most women felt alone, as they did not disclose to closest family members for fear of being stigmatised. These findings are supported by literature as indicated in Chapter 5.

### 7.4.2 Theme 2: Unplanned pregnancy

Most participants experienced either IPV or reproductive coercion which is common among adolescents as reviewed literature confirms. Childbirth to teenage mothers in South Africa tends to take place outside marriage as compared to other sub-Saharan African countries (Macleod & Tracey 2010:21) especially when the pregnancy is unplanned and unwanted.

Teenage pregnancy, especially among the 16 year olds and younger, may introduce additional physical and emotional stress into an already stressful developmental period (Lowdermilk et al 2016:72), as well as poor coping after abortion (Foster et al 2011:84). In the process of trying to establish an independent identity, many teens do not realise the consequences of their sexual behaviour. On the contrary, younger women are less likely to speak to their partners about contraceptive use than older ones (Manzini 2001, as cited in Macleod & Tracey 2010:25).

Some women in the present study, experienced reproductive coercion, which is a type of IPV, at the hands of their partners, as they reported that their male partners started being violent after learning about their pregnancy. Coercion was in the form of physical violence, verbal abuse, behaviours to control the outcomes of the pregnancy, including coercion to either continue or terminate the pregnancy, among others. With some relationships, the male partner practiced infidelity by cheating on the partner, while with others, male partners simply disappeared. In the face of physical and verbal abuse, most participants decided to secretly terminate their pregnancy, without informing their partners.

The findings of this study support the results of other studies (Miller & Silverman 2010:515; Williams et al 2008:14), that during pregnancy, women may face an

increased risk of intimate partner violence, where a partner would be physically or emotionally abusive after learning of the partner's pregnancy or try to control the outcomes of the pregnancy. In addition, unintended pregnancy occurs more commonly for women in violent relationships (Otwombe, Dietrich; Sikkema, Coetzee, Hopkins, Laher & Gray 2015:1).

Contrary to the findings of some studies on women abuse (Bezuidenhout 2017:250; Moloko-Phiri 2015:149), that women who rely on their partners for financial support have no decision-making power about their pregnancy outcome, it was apparent from the present study that participants who experienced RC or IPV managed to decide to leave their abusive partners. In this study, 25 of the participants broke up with their partners before or after TOP, two participants got married to their partners after terminating the pregnancy and three were already married by the time they terminated pregnancy.

All the pregnancies were unplanned and unwanted for a number of reasons like, desire to continue with studies, lack of financial support from the partner, unemployment or simply because the woman felt not ready for a baby. Of the 30 participants, 25 were single and 14 were unemployed. Initially, all felt that TOP was the right thing to do, but after TOP the guilt and the regret set in. There was sadness.

### 7.4.3 Theme 3: Intra- and Interpersonal relationships

At intrapersonal level, most participants stated that they were feeling guilty, sad and ashamed. They expressed that they have wronged God and their unborn babies. In a study on the preferences for psychological treatment after TOP among college students who experienced psychological distress, Curley and Johnston (2014:318), reported that student participants expressed the desire for assistance with spirituality. For this age group, spirituality plays an important role in death and loss. Therefore, losing a pregnancy often provokes questions concerning values as well as the meaning of life and death. This desire suggested that participants took their abortion seriously and they therefore aimed for resolving the experience. In the present study, some participants may have recognised the humanity of the foetus or the transcendent nature of abortion as a death experience. This concern by participants may reflect their need for closure,

for forgiveness from a Higher Power, for self-forgiveness and the significance of the abortion experience (Curley & Johnston 2014:318).

Most viewed TOP as murder and that they committed a sin against God. Some felt that they have forgiven themselves whereas others stated that with time, they will come to forgive themselves. At the time of TOP, most were without partner support. Most had not disclosed to family for fear of being judged. Although they all expressed that they were treated well at the TOP clinic (except one), some were discriminated against in church and in the community. Some stated that they felt unworthy of attending church after terminating their pregnancies. All, except one, indicated that they are praying to God for forgiveness. They would thereafter forgive themselves. According to the International Seminar report paper on decision making regarding abortion (IUSSP Scientific panel on Abortion Research, Lagos (2014:5), the weight of religious factors have a strong influence on TOP behaviour and TOP decision. This research also identified important religious and cultural factors that should be considered when counselling women before and after TOP.

Typically, most of the relationships with the father of the baby ended abruptly, probably because they could not accept these women in their distressed state. A few of the participants expressed that, to find closure, they needed to grieve for their aborted babies, through proper disposal or burial of the products of conception or by cleansing rituals. Instead, some churches discriminated against them after learning of their TOP. There was no funeral, memorial or acknowledgement of what happened (Chavier 2015:69). Most participants feared disclosing about TOP because they would be viewed as murderers. Some women expressed that TOP was irreversibly over, and it was this reality that needed to be grieved. Grieving was a necessary step towards healing. Grieving for an aborted baby was different because the mother was part of the decision that made TOP happen.

It also emerged that time since the TOP was generally not a significant factor for self-forgiveness, meaning that for self-forgiveness, as commonly assumed, time may not heal. This was evident in that some participants who were 35 years old and terminated pregnancy during adolescence, were still feeling hurt and guilty or shameful about the experience. On the other hand, as noted by Terzino (2010:51), time is a less important

factor in the case of TOP since the “victim” is the woman and because the aborted baby was no more.

### 7.4.4 Theme 4: Experience of caring by the health personnel

Although they were treated well at the TOP clinic, they felt scared of the procedure. Good treatment at the clinic helped to resolve their confusion about their decision to terminate the pregnancy. The good treatment encouraged them to ask questions.

### 7.4.5 Theme 5: A need for counselling and advice sessions

Some participants wished the clinic manager should have allowed them to go home for a week to think about TOP as sometimes they are still confused when reporting to the clinic for TOP. On the contrary, some seriously wanted the nurse to talk about her feelings as TOP is emotionally draining. Many come to report to TOP clinic and had never discussed TOP with anyone. More importantly, all participants appreciated the good treatment because most said that they came to the clinic still confused, not knowing whether to do TOP or not. Therefore, if the clinic personnel were unfriendly to them, it causes even more confusion. As a result, talking to the professional nurse was important. A few wished they could have been advised before TOP to tell someone about it so that they have support after terminating the pregnancy. Still a few needed reassurance that what they did (TOP) was not wrong. One participant actually stated that she still needed to know the truth from a professional person, about TOP. Generally, there is a need for improvement in pre- and post- TOP counselling, especially about what to expect after TOP.

## 7.5 LIMITATIONS AND STRENGTHS

The limitations and strengths of the study will be discussed separately.

### 7.5.1 Limitations

The current study should be accepted against the following limitations:

- During data collection, participants shared many narratives with the researcher. The large amount of data collected meant that the researcher could record only some of the stories in this thesis, resulting in constituting only partial truths for the study. Although the report was constructed from the active voices of the participants, the story lines were selected by the researcher to clarify specific themes.
- The study relied on participants' recall. Previous research has revealed issues with retrospective memory, namely, that individuals tend to recall events in a self-enhancing manner (Terzino 2010:60). It is possible that participants could have been biased in recalling their experiences about TOP.
- Lack of diversity of the participants, which may limit the generalisability of the current study. The sample consisted of 30 women recruited from one Health Care Centre in Gauteng Province, in South Africa. The sample consisted predominantly of Blacks because the Health Centre serves a number of low socio-economic informal settlements for Blacks. Future research carried out in a more diverse population could produce different results.
- Even though the sample provided a relatively rich data, the sample size reduced the representativeness as well as the generalisability of the study findings to a wider community.
- To explore women's experiences about TOP, the present study relied on the use of self-report measures. Self-reports indicate participant's own perception of behaviours and feelings. It is worth noting that individual perceptions may not be consistent with the behavioural manifestations of observed attitudes and interactions. As a result, what people report themselves to be doing may not necessarily be consistent with their observed behaviour.
- Topic sensitivity and social appeal could have contributed to participants under-reporting abuse or TOP experiences.
- Period of data collection was also a limitation. The researcher collected data over two months. The period was too short to do prolonged engagement, which could have helped the researcher in understanding the women's perspectives.

### 7.5.2 Strengths

Despite the above limitations, the following strengths emerged:

- The major strength was that the study was conducted in a place that participants were familiar with. The participants also knew some of the health personnel at the Health Care Centre. This created an environment with a friendly atmosphere for developing relationships with one another.
- The philosophical approach of interpretive phenomenology guided the study and thereby enabled the researcher to remain sensitive to her own assumptions about TOP in order to eliminate researcher's bias.
- The use of a common language by all participants and the researcher reduced loss of meaning. This enabled true representation of participants' words.

## 7.5 UNIQUE CONTRIBUTIONS OF THE STUDY

The study has made pertinent contributions to the knowledge on TOP. Some of the unique contributions made are listed as follows:

- It emerged that it is important to offer culture congruent care. Recognition of religious and cultural practices about grieving the aborted baby was one of the lessons that the researcher learnt from participants. The sentiment of supporting practices like burying the products of conception or the foetus, confessing guilt or asking for forgiveness from the aborted foetus or even naming the foetus or the pads that were stained with the blood from the products of conception were found helpful in assisting the bereaved women who terminated pregnancy to find healing. Creation of space for grief to occur would enable the woman to feel worthy.
- Another unique contribution of the study to the current literature is that the women who terminated pregnancy demonstrated resilience in the midst of having to cope with emotional pain, guilt and shame for 'murdering' their unborn babies, being deserted by their partners, and many a time bounded by poverty, discriminated by the church and stigmatised by the community and yet hopefully asking God for forgiveness of their sin of murder. Psycho-education would assist participants to gain knowledge and to become more resilient.
- The development of a model on self-forgiveness for women who terminated pregnancy in adolescence is a major contribution. This model would directly

support counsellors and reduce guilt and anxiety suffered by adolescents and promote mental health. Indirectly, this model might reduce teenage pregnancy, lessen the rate of TOP and safe the government money on TOP.

## 7.6 RECOMMENDATIONS

### 7.6.1 For nursing curriculum

Findings confirm that self-forgiveness education is very basic**.** This could be attributed to the curriculum design of the R425, SANC Regulation for the Diploma in Nursing (General, Psychiatry and Community) and Midwifery (SANC 1985).

The curriculum of the Diploma in Nursing (General, Psychiatry and Community) and Midwifery needs to be adapted. In addition, self-forgiveness empowerment should be introduced earlier in the programme in order to equip students with intervention strategies to deal with situations of guilt and shame after TOP. Moreover, self-forgiveness should be included as a comprehensive module in the curriculum to better prepare students on counselling techniques. Over and above, the curriculum of Gauteng Nursing Colleges, R425 (Diploma in General, Psychiatry and Community) and Midwifery should be adapted such that psychiatric nursing skills are introduced concurrently with General nursing (SANC 1985).

According to the new curriculum, the programme R171 (SANC Regulation relating to the Approval of and minimum requirements for the Education and Training of a leaner leading to Registration in the category of Staff Nurse) (SANC 2005), the focus is on General nursing only, for the duration of three years. Inclusion of a module on self-forgiveness will enhance emotional and professional maturity.

### 7.6.2 For nursing education

Nursing students require education and training to render optimal emotional care to adolescents and women who have terminated pregnancy. Therefore**,** empowerment of students with psychosocial skills should be an integral part of nursing education in order to achieve and maintain quality clinical performance. Self-forgiveness is one of the topics that should be taught at an early stage of training. A greater awareness,

knowledge and skill of self-forgiveness counselling will empower student nurses optimally.

### 7.6.3 For nursing practice

- Given the intrapersonal and interpersonal benefits associated with self-forgiveness, health professionals and counsellors involved in counselling women who terminated pregnancy and are struggling with guilt, shame, regret, and personal distress empathy are encouraged to consider self-forgiveness as part of the treatment goal.
- Pre- and post-TOP counselling should be detailed and should have a checklist on important aspects to cover when counselling. A study conducted by the author (Sebola 2014:62) stress the importance of a holistic approach to counselling, which takes into consideration the religious and the cultural beliefs about TOP.

  More importantly, health institutions where TOP services are provided should provide guidelines, policies and procedures to empower health personnel to provide emotional support to women who terminated pregnancy. Collaborative health team meetings and clinical discussions need to be held for effective empowerment that will enable provision of quality care to women after TOP. Narratives provided by participants revealed that they sometimes come for TOP being very confused and needing to talk to someone for clarity. Such mental confusion may lead to guilt and shame related to TOP. Regular workshops on self-forgiveness for health professionals should be conducted. Discussions of scenarios from real life situations will make such workshops effective.
- In support of policy and programme commitments made at the International Conference on Population and Development (Santhya & Jejeebhoy 2015:190), governments need to note that future success of SRH of adolescents (boys and girls) requires increased political will and engagement of young people in the formulation and implementation of policies and programmes, along with increased investments to deliver comprehensive sexuality education, approachable and non-judgemental health services, safe spaces programmes especially for vulnerable girls, and programmes that engage families, communities and societies. Stronger policy-making and programming also require expanding the evidence on adolescent health and rights in low-income

and middle-income countries (LMICs) for boys and girls adolescents and relating to key health matters affecting adolescents.

- Major among factors that compromise girls' SRH and rights include lack of knowledge and agency, services tailored to girls' specific needs and situations and a supportive environment (Santhy & Jejeebhoy 2014:13).

  There is a need for governments to consider applying UNESCO's international guidance for programmes on abstinence, information about contraceptives, comprehensive sexuality programmes that address issues of gender and power as well as fulfilment of adolescent boys' and girls' human rights. More importantly, safe spaces for girls, including supportive parent-child relationships, supportive teachers, supportive families, supportive peers and safe schools are needed to protect adolescents' rights and meet their needs. These are most likely to have positive SRH outcomes for adolescent girls.
- Self-forgiveness can, even though there could be other strategies, be included as a coping strategy to situations of guilt and shame related to TOP because these emotions create stress for an individual. Incorporating a self-forgiveness intervention in existing treatment protocols, for example, of TOP, may be beneficial in enhancing an individual's ability to refrain from shame and guilt (Scherer, Worthington Jr, Hook & Campana 2017:392).
- Although the self-forgiveness intervention is geared towards TOP in the current study, it should not be limited to that type of transgression (Scherer 2017:393). Self-forgiveness has been useful in augmenting alcohol abuse treatment protocol (Scherer et al 2011:382), interventions pertaining to drug abuse (Lin, Mack, Enright, Krahn & Baskin 2005 as cited in Scherer et al 2011:3), among others.
- Screening and assessment are important for detection of IPV and RC. All females, regardless of their perceived risk, should be universally screened in confidential environments. Screening for RC and IPV can be done concurrently with routine family planning services, TOP services and routine annual visits. Practitioners serving in SRH settings should include discussion of sex partners and behaviours as current standards of care, and where necessary, recommend sexual health protection and refer clients that report violence to services specific to partner abuse (Silverman et al 2011 60).
- Education of health care providers, the general public, the churches, school-based and community-based education about RC and IPV are all essential.

- Contraceptive methods that are less susceptible to detection or tampering should be recommended to women who experience IPV or RC (Park et al 2016:76).

### 7.6.4 For future research

Studies could further look into the link between guilt, shame and reproductive coercion within the cultural and spiritual practices.

- More research is needed on self-forgiveness as a process because most studies have focused more on the outcome of self-forgiveness.
- The researcher's model has not been empirically tested. Future research is needed in this regard. Particular usefulness of each component of the model in the present study can be tested. Potential outcomes of neglecting specific components can also be investigated.
- In applying the components of the present model to assist women who terminated pregnancy during adolescence, interventions can be developed and thereafter be tested for effectiveness with specific populations who have different cultural backgrounds.
- Future self-forgiveness research can also identify the best methods of helping clients to accept responsibility for the harm they caused to themselves or their spiritual higher being. The study should investigate how individuals who undergone TOP can work through shame and guilt in the context of their cultural and religious beliefs, and engage in restoration, recommitment and reconstruction efforts to inspire personal growth, self-compassion and self-acceptance.
- This study also identified the importance of measuring certain aspects of individuals' personality differences when conducting research on self-forgiveness. According to Terzino (2010:53), such information is relevant and important for self-forgiveness interventions because particular personality traits may hinder the self-forgiveness process or the lack of self-forgiveness may result in reduced levels of mental health. Other most important personality measures to examine in subsequent research, according to the author, may be depression, anxiety and narcissism. It is important to determine if self-forgiveness affects personality or personality affects self-forgiveness, in order to make causal

inferences. In the present study, the researcher only checked participants for rumination and for their emotional state before TOP and this was found to be insufficient.

- As data were collected from a Health Care Centre close to and serving a predominantly Black community, residing in an informal settlement, the vast majority of participants were Blacks. It would be beneficial to replicate this study in more ethnically diverse populations.
- Perceived forgiveness from, and conciliatory behaviour towards a higher power emerged as a strong correlate in intrapersonal transgressions such as TOP. This has logic, given that there is no other person to apologise to in an intrapersonal transgression of TOP. Instead, believing that a higher power has forgiven the self may benefit the self-forgiveness process. This aspect was important for examining self-forgiveness particularly for self-forgiveness associated with TOP.
- There is a need for research on issues around early child marriages, sexuality education, factors associated with teenage pregnancy and strategies to curb it amongst boys and girls.
- Explorative studies on the drivers of teenage pregnancy, in particular, gendered norms, knowledge, access and use of contraceptives as well as the barriers and facilitations to teenage mothers returning to school.

## 7.7 CONCLUSION

Cultural and religious expositions, self-blame and condemnation, including intimate partner violence with reproductive coercion remained as key findings of the study. The findings are well supported in literature, except for cultural and religious expositions, which, although studied before, did not necessarily have relevance to TOP. The idea of self-blame and self-condemnation, as espoused in this study, has long-term effects on the health of adolescents and their transition to adulthood. The findings formed a foundation for the self-forgiveness model. The research identified the importance of the contexts of culture and religion in relation to self-forgiveness for women who terminated pregnancy, especially Black women.

The context of culture and religion in relation to TOP and self-forgiveness were guided by the understanding of the social-ecological model, which depicts the dynamic

relationships amongst individuals, groups and environments. According to the ecological model, individuals are understood to influence and be influenced by people and organisations with whom they interact.

Complex emotional experiences related to TOP, as described by participants, included mainly guilt, shame, regret, as well as self-condemnation. All participants perceived TOP as death and participants confessed that they killed or murdered their innocent babies, instead of protecting them.

Most participants also experienced anxiety about sterility related to TOP and this was interpreted as punishment. Such perceptions about TOP were mediated by the cultural, moral and religious contexts within which these women were positioned. Of the 30 women interviewed, 28 were Christians, one a Muslim and one was not affiliated to any religion. Women's perception of the foetus was influenced by their religion, for example, Islam views that ensoulment takes place within 120 days after conception (Mabel et al 2008: 6), whereas Christianity belief that a foetus is alive from conception. Over and above, Christianity views TOP as murder. All participants referred to the foetus as a baby and the language used to describe the foetus reflected the closeness that women felt towards the life that grew in their bodies. This life impacted on the women's post-TOP emotional reactions (Mabel et al 2008:6).

The model developed was based on three main findings, namely, self-condemnation and self-blame, cultural, and spiritual aspects as well as reproductive coercion. These will have an impact on counselling for self-forgiveness. There is need for further research to test the model as well as the concepts that make up the model.

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# ANNEXURES

# ANNEXURE A

# UNISA ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES**

**REC-012714-039 (NHERC)**

7 December 2016

**HSHDC/564/2016**

Mrs BR Sebola

Student: 294-191-0

Supervisor: Prof GB Thupayagale-Tshweneagae

Qualification: D Tech

Joint Supervisor: -

Dear Mrs BR Sebola

**Decision: Ethics Approval**

---

**Name:** Mrs BR Sebola

**Proposal:** Self-forgiveness for women who terminated pregnancy in adolescence.

**Qualification:** DPCHS04

---

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

*The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 7 December 2016.*

*The proposed research may now commence with the proviso that:*

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

*Note:*
*The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.*

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za



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# ANNEXURE B

# APPLICATION TO CONDUCT THE STUDY

PO Box 156

Atteridgeville

0008

06.07.2017

The Chief Executive Officer

Laudium Community Health Centre

Laudium

Pretoria

0001

Dear Sir/Madam

My name is Botshelo Rachel Sebola.

I am currently studying for a D Phil et Litt degree with the University of South Africa.

The topic of the study is: **Self-forgiveness for women who terminated pregnancy during adolescence.**

I hereby kindly request permission to recruit potential participants from your institution to be included as a sample for this study.

Personnel who work in the family planning clinic or the gynaecology clinic will be requested to inform any relevant client whether they would be interested to be part of the study. The researcher will thereafter explain the details of the study to the willing client, after which the researcher will make an appointment for a one -on-one interview.

For privacy and confidentiality, the researcher is also requesting the use of a private office/ room where to conduct the interviews. Interviews will be conducted wherever the client wishes, that is, in or outside the premises of the Community Health Centre. To reduce exhaustion, participants will be offered a snack during the interview.

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 study 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

# ANNEXURE C

# APPROVAL TO CONDUCT THE STUDY

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Lufuno Razwiedani
Tel: +27 12 451 9036
E-mail: lufuno.razwiedani@gauteng.gov.za

**TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE**

**PROJECT NUMBER:52 /2017**
**NHRD REFERENCE NUMBER: GP_ 2017 RP 19112**

**TOPIC:** Self-forgiving strategy for women who terminated pregnancy in adolescence

**Name of the Researcher:** Ms.Rachel Sebola

**Name of the Supervisor:** Prof. G. Thupayagale-Tshweneagae

**Name of the Department:** Health Studies

University of South Africa

**Name of facilities:** Ladium CHC

***NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND***

***NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.***

**DECISION OF THE COMMITTEE: APPROVED**

.....
**Dr. Lufuno Razwiedani**
**Chairperson: Tshwane Research Committee**
**Date:** 28/07/2017

pp .....
**Ms. M Lerutla**
**Acting Chief Director: Tshwane District Health**
**Date:** 2017/07/28

## ANNEXURE D

# PARTICIPATION INFORMATION LEAFLET AND CONSENT FORM TO PARTICIPATE IN THE STUDY

**TITLE OF THE STUDY: SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY IN ADOLESCENCE**

**Month and Year**

Dear Participant

**Introduction**

My name is Botshelo Rachel Sebola. I am currently studying D Litt et Phil in Nursing Science with the University of South Africa. I am inviting you to take part in this study and your permission is hereby requested. This information leaflet will enable you to understand your role in this study.

**Purpose of the study**

The purpose of the study is to develop a model of self-forgiveness for women who terminated pregnancy during adolescence.

**Procedure to be followed**

Your participation in this study is kindly requested. During participation you will be expected to respond to questions during an interview. The interview will last about one hour and thirty minutes.

**Benefits of the study**

The results of this study will contribute to the knowledge base on the experience of termination of pregnancy by choice.

The findings of this study will improve the content of counselling clients prior to termination of pregnancy and during follow up.

The findings will also be useful for better care of adolescents after termination of pregnancy.

**Risk and Discomfort**

There is minimal risk of emotional discomfort which may be caused by recalling the event of abortion. There are counsellors at the TOP clinic of the health centre. You will therefore be supported and referred when the need arises.

Your input in this study will take your time and effort.

**Confidentiality**

Throughout this study confidentiality will be maintained. Any information that you provide will be kept confidential. Results will be published and presented in such a manner that you as a participant will remain anonymous.

**Your rights as a participant**

Participation in the study is voluntary. You have the right to withdraw from the study at any time.

**Information and contact person/researcher**

In case you have any questions or you experience any problems, contact the following persons:

**Researcher**: Rachel Sebola
**Cell**: 0798200125
**Email Address**: brsebola@gmail.com
**Supervisor:** Prof GB Thupayagale- Tshweneagae
**Telephone:** (012) 4292195

## Consent to participate in this study

Your consent to participate in this research is subject to reading and accepting the above information and signing the informed consent document below. You will be provided with a copy of the signed consent.

**INFORMED CONSENT**

I have read the above information leaflet and fully understand what is expected of me. Its contents have been explained to me. I have been given the opportunity to ask questions and received the necessary answers to my satisfaction. I hereby agree to take part in this research.

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Signature of participant: ---------- Date: ----------

Signature of researcher: ---------- Date: ----------

# ANNEXURE E
# INTERVIEW GUIDE

## RESEARCH TOPIC: SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY DURING ADOLESCENCE

**Date of the interview:**

**1. Before the interview or dialogue, the following information related to the women's context was collected about each participant:**

- Age
- Ethnicity
- Number of previous abortions
- Number of children
- Marital status
- Level of education
- Vocation
- Religious background
- Mental health before termination of pregnancy
- Did you have a close person after TOP
- Do you easily forgive ?

**2. QUESTIONS AND PROBES:**

**Grand tour question: "Tell me how you have experienced termination of pregnancy during adolescence."**

**Objective no 1**

To explore the lived experiences in terms of the feelings of guilt, reproductive coercion and self-forgiveness of women who terminated pregnancy during adolescence

**2.1 We are going to talk about your experiences related to TOP, guilt, coercion and self-forgiveness**

**Specific questions**

- Tell me what you think of TOP with reference to yourself

- Probes depending on the answer

- I want you to make me understand what makes you think you were coerced?
- Explain more what did this coercion mean to you?
- How would you describe the feelings of those who coerced you to TOP, at the time when they asked you to terminate?
- What are your feelings about TOP from then until now?
- What have you learnt about your experience of TOP?
- What does TOP mean to you?
- What do you think could be done for you to allow you to go on with your life without thinking or feeling guilty about TOP?
- Who do you think should do that?

**Objective no 2**

To describe the effects of the lived experiences of the women in terms of relationships, the community and the society.

**2.2 The next questions are about yourself, relationships with spouse or partner, with the community and the society**.

**Specific questions**

- How is your relationship with others now as compared with the past, before TOP?
- How do you feel about the community, that is, the church, workplace, clubs, the neighbours, relatives, friends and so on, in relation to accommodating you after termination of pregnancy ?
- What were the feelings of health care workers about you when you sought to terminate pregnancy?
- What did this type of treatment mean to you?
- Should they have done it better?
- What was your relationship with those who coerced you?

- How is your relationship with yourself before and after TOP?

- Share with me your relationship with the Higher Being?
- What does this relationship mean to you?
- What do you think should be done to help you be at peace with self?
- What is your relationship with children, partner, work and at church?
- Is there anything else that can be done to improve these relationships
- Have you done anything ritual (**a cultural essence**) related to this TOP?
- What does this ritual mean to you in relation to TOP?

**Objective no 3**

To develop a conceptual model of self-forgiveness for enhancement of counselling of women who terminated pregnancy during adolescence.

## 2.3 Let us talk about self-forgiveness

**Specific Questions**

- Have you forgiven yourself after TOP?
- If yes, how do you experience self-forgiveness?
- If no, how do you experience not forgiving yourself?
- What does it **mean** to you to forgive or not to forgive yourself ?
- Share with me what you think should be done so that you can stop blaming yourself.
- Who must do it, when and where must it be done?

## 2.4 Other questions

- When there is silence: “share with me what you are thinking.”
- “Tell me more”: elaboration probe
- “Í am not sure what you mean by that” : clarification probe, for deeper explanation.
- “Please go on, I am not sure I understand” : when you need more/deeper explanation.
- Uh-huh probe: encouraging the participant to continue.
- Echo probe: repeating the last item the participant said, and asking them to continue.

# ANNEXURE F

# TABLE 4.1: THEMES, SUB-THEMES AND STORY LINES

| Categories | Sub-categories | Story Lines |
|---|---|---|
| 1. Transgressing one of nature's strongest instincts: the mother's protection of her young | 1.1 Women who terminated pregnancy in adolescence experienced:<br>1.1.1 Feelings of guilt about TOP<br>1.1.2 Emotional pain<br>1.1.3 Feelings of sadness<br>1.1.4 Fear of not conceiving | |
| | 1.1.1 Feelings of guilt about TOP | "I was upset about my boyfriend but there after I regretted it…I regret TOP…"(P2)<br><br>"So I decided to get an abortion, but I feel guilty even now…" (P15)<br><br>"…I must be honest it does not settle with me very well because that's an innocent child" (P18)<br><br>"I feel I made mistakes, guilty…I don't know whether God has forgiven me…"(P6)<br><br>"…that is why I feel guilty. Even though I did it, it does not mean I have accepted my decision…"(P10)<br><br>"…even now I feel bad about the termination…"(P13)<br>(P23; P24; P29) |
| | 1.1.2 Emotional pain | "Because it is emotionally painful…"(P3)<br><br>"Taking out an innocent…blameless child is painful thing…"(P5)<br><br>"It is emotionally a painful experience…I asked myself why would I do such a thing?" (P6)<br><br>"…I don't like remembering that part of my life, because it was very painful…" (P8)<br><br>(P23; P27; P31) |

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| | 1.1.3 Feelings of sadness | "It makes me feel sad…it hurts me…" (P4)<br><br>"I feel hurt…to tell the truth to terminate pregnancy is not the right thing to do" (P5)<br><br>"I feel depressed" (P13) |
| | 1.1.4 Fear of not conceiving in the future | "The risk that I may not be able to conceive a child worries me. I still think will I have a child in the future" (P2)<br><br>"My womb, what if it does not conceive…I think a lot especially about around that the time when I will need another 2nd child" (P6)<br><br>"…I was worried what if something had gone wrong with TOP, what if I can't have other babies…" (P8)<br>"I was scared for the future, asking myself: 'am I ever going to have other kids or what?'…" (P24) |
| 2. Unplanned pregnancy | 2.1 Right to terminate due to:<br><br>2.1.1 Relationship problems<br><br>2.1.2 Unwanted pregnancy<br><br>2.2 Right thing to do | |
| | 2.1.1 Relationship problems | "…when I became pregnant. I did not tell him because he was starting to be abusive, he started hitting me and being violent for any mistake he would hit me…" (P1)<br><br>"He started being angry, saying…he forced me into sex relationship…I fell pregnant" (P6)<br><br>"He used to beat me. He was an alcoholic, he used to beat me & the children…" (P10)<br><br>"…he controlled me regarding socialising with other people…I had to pay with my body" (P12)<br><br>"I had conflict with my partner. So I terminated the pregnancy because of my problems with my partner" (P11) |
| | 2.1.2 Unwanted pregnancy | "…but because I got pregnant unprepared I decided…I have a nagging feeling it came at a time I did not plan…" (P1)<br><br>"…we have various reasons why we want |

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| | | to terminate. It was an unwanted pregnancy…" (P20) |
| | 2.2 Right thing to do | "The child was innocent. I had no choice but to do it…" (P4)<br><br>"So I had to make a decision if I am going to keep it or terminate it and I was not ready to be a single mother" (P6)<br><br>"…I did it because of some reasons, otherwise I would not have terminated it" (P5)<br>"…even now I don't have regrets that I terminated the pregnancy because I was not ready to have a child" (P20)<br>"It's a good decision because sometimes you can have a baby without a plan…" (P32) |
| 3. Intra and interpersonal relationships | 3.1 Intrapersonal<br><br>3.1.3 Relationship with self (negative aspects)<br>3.1.3.1 Viewed self as a "murderer" (killed an innocent child)<br>3.1.3.2 View self as having committed a sin<br><br>3.1.2 Relationship with self (positive aspect)<br><br>3.1.2.1 Experience self-forgiveness<br><br>3.1.2.2 Experience not having forgiven self<br><br>3.1.3 Relationship with God<br><br>3.2 Interpersonal<br><br>3.2.1 Relationship with partner<br>3.2.2 Relationship with family<br><br>3.2.3 Relationship with community<br>3.2.3.1 Fear of being ostracised | |
| | 3.1.1 Relationship with self (negative aspects) | "The child was innocent…TOP is like killing…" (P4) |

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| | 3.1.1.1 Viewed self as a "murderer" (killed an innocent child) | "…it means I committed sin…I am murderer. I killed innocent blood" (P6)<br><br>"It's a human being and I killed it…I denied it the chance of coming into this world" (P8)<br><br>"I feel like a murderer…" (P10)<br><br>"…So when you abort you are killing…" (P11)<br><br>"It's like killing your own child …because already everything is formed…" (P13)<br><br>"You know to terminate pregnancy, it makes me feel like I am killer. I have killed someone…" (P18)<br><br>"We kill innocent blood…children who know nothing…" (P5)<br>(P28; P29;) |
| | 3.1.1.2 View self as having committed a sin | "It's same as you made a sin in the eyes of God… you feel you committed sin but everyone deal with it her own way" (P3)<br><br>"…I have done a sin…it means that I have done wrong in God's eyes" (P9)<br><br>"…I made a sin here on earth…God knows that what I have done is sinful" (P14)<br><br>"You can't have pregnancy tomorrow & say that you are going to terminate. It is to kill, it's a sin" (P16)<br>(P30; P31) |
| | 3.1.2 Relationship with self (positive aspect)<br><br>3.1.2.1 Experience self-forgiveness | "I have a conscience that does not feel guilty. So I have to forgive myself that I have done this…I had to forgive myself before someone else could forgive me" (P1)<br><br>"I have forgiven myself. I don't think about anymore…I have accepted it happened, its gone…" (P3)<br><br>"…I chose to forgive myself…" (P7)<br><br>"…I first asked for God's forgiveness. Then after that I forgave myself" (P10)<br><br>"…there came time when I said to myself." |

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| | | "People who can't forgive themselves should go for counselling. I think they will have to be reminded of the main reason they did that (TOP) so they understand and accept it." (P33) |
| | 3.1.2.2 Experience not having forgiven self | "I never had time to forgive myself…I haven't forgiven myself…" (P2)<br><br>"…I haven't forgiven myself…I don't know about self-forgiveness" (P5)<br><br>"…I am still asking forgiveness because I don't know it, I will be accepted…" (P9)<br><br>"It will take time to go to the position where I was before abortion" (P17)<br>(P15) |
| | 3.1.3 Relationship with God | "I must ask forgiveness from God. In our church there is somebody to whom I can report what I have done…I have to ask forgiveness from Him" (P2)<br><br>"I have to ask for forgiveness from God when praying. I believe God answered my prayers on forgiveness for my termination…" (P3)<br><br>"…I always pray to ask Him to forgive me…I confessed my sin of TOP because with God there are no secrets" (P6)<br><br>"I need God in my life. God has forgiven me" (P7)<br><br>"…I feel that God has forgiven me…"<br>(P10)<br>"I just ask God to forgive me…" (P16)<br><br>"Because there is no secret you can hold against God….I have to ask for forgiveness" (P1)<br>(P20; P24; P26; P30) |
| | 3.1.4 Prayer as a way towards forgiveness | "What is done is done. What is needed is that I must be strong, attend church…for God to forgive me" (P4)<br><br>"I prayed about my guilt. I asked confessed my sin of terminating pregnancy…" (P6)<br><br>"Pray, I pray to God…during procedure I told God I am killing a person forgive me. Hold my hand God through this |

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| | | procedure" (P7)<br><br>"I was encouraged by the Bible…I forgot it. God said we must not kill…so I had to go on my knees and ask for forgiveness" (P9)<br><br>"…I can't live without. I am in prayer all the time. Anything I do and say I pray about it" (P10)<br>(P13, P15 ,P17, P18; P31) |
| | 3.2 Interpersonal<br>3.2.1 Relationship with partner<br>3.2.4 Relationship with family<br><br>3.2.5 Relationship with community<br>3.2.3.1 Fear of being ostracised | |
| | 3.2.1 Relationship with partner | "I stopped the relationship after pregnancy…" (P2)<br><br>"He loved girls, no financial support, we parted after termination" (P3)<br><br>"We parted…he went away, I left him to go, I did not follow him…" (P5)<br><br>"…even now we don't talk…" (P9)<br>"We are fighting. When I checked my messages on my phone, he told that it is<br><br>over because I terminated…" (P32) |
| | 3.2.2 Relationship with family | "I disappointed them through falling pregnant" (P7)<br><br>"…My family my auntie especially her relationship with me is not that right…" (P7)<br><br>"I'm very close with my mom. But I decided that I am not going to share this with my mom…" (P20) |
| | 3.2.3 Relationship with community<br>3.2.3.1 Fear of being ostracised | "…people will see me as a murderer…it may not be acceptable…" (P1)<br><br>"I fear people will speak badly of me that I terminated pregnancy…a woman is not accepted in the community after TOP" (P5)<br><br>"You can't spread it to others, you are still scared about it…you don't tell others what |

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| | | you did, because you did exactly what your parents told you not to do" (P6)<br><br>"They judge you. Painful to be judged when a person does not know the reasons for TOP" (P7)<br><br>"…I feared sharing because people take abortion to be wrong…" (P11)<br><br>"I know they are judgmental…" (P13)<br><br>"You know some people can judge you, but I will say if those people can put themselves in your shoes, they will understand what you are going through & they wouldn't be judgemental…" (P18) (P20; P27) |
| | 3.2.3.2 Relationship with church | "I stopped going to church for 3 months, because church law does not allow attending church when you have done TOP because this dirtifies the church" (P2)<br><br>"…at my church they gave me six months to stay by myself away from church…" (P9)<br><br>"…so I don't feel like going to church, it's a very big deal." (P13)<br><br>"I pray that one day I can go to church" (P15)<br><br>"…sometimes I go to church sometimes I do not go. Sometime I take six months or nine months not going to church" (P30)<br><br>"…I stopped going to church because it's like I am liar in the face of God. I may ask something from God but God will know I am murderer… " (P23) |
| 4. Experience of caring by health care professional | 4.1 Being cared for by HCP | "With love…she is loving, the sister" (P1)<br><br>"They treated me well…they are good, patient, they treat people well…" (P5)<br><br>"…I was treated well and follow up treatments have also went well…they showed love ,they showed humanity" (P9)<br><br>"…the sister treated me well…" (P12)<br>"supportive and positive…" (P3) |

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| | | "…I liked the way she treated us, she was not harsh on us, she was kind and she was open to us…not afraid to ask questions, due to the way she approached us…" (P19) |
| 5. A need for counselling and advice sessions | 5.1 Counselling and information giving sessions | "…ask her to take about a week to think about termination before it is done, then come back on such and such a date" (P3)<br><br>"…before everything she explained the whole procedure…on how it works…" (P19)<br><br>"…Counselling, because talking about it is important…then they can help you on the right path" (P1)<br><br>"…sister should speak to me about my feelings. She must uplift and encourage me" (P5)<br>"…Sister gave us papers that told us about risks of TOP….that the risks are there…" (P2)<br><br>"…she should tell you what will happen after termination…that you should tell someone about it & you could lose your life…" (P1) |

## ANNEXURE G

## LETTER FROM THE EDITOR

# EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

21 January 2018

**TO WHOM IT MAY CONCERN**

This letter serves to confirm that I have edited and proofread Ms BR Sebola's thesis entitled: **"SELF-FORGIVENESS FOR WOMEN WHO TERMINATED PREGNANCY IN ADOLESCENCE."**

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:

JM Chokwe

Jack Chokwe (Mr)

Contact numbers: 072 214 5489

jackchokwe@gmail.com

http://www.academicproeditor.com

Professional EDITORS Guild