A descriptive study of women approved for abortions in a general hospital.

Beverly A. Freeman

University of Windsor

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The School of Social Work

A DESCRIPTIVE STUDY OF WOMEN
APPROVED FOR ABORTIONS IN A
GENERAL HOSPITAL

by

Beverly A. Freeman

A Thesis
submitted to the Faculty of Graduate Studies
through the School of Social Work in partial fulfillment
of the requirements for the degree of Master
of Social Work at the University of Windsor

June, 1976

Windsor, Ontario, Canada
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ABSTRACT

The purpose of this study was to describe a group of women who had requested and who had received approval from an abortion committee of a general hospital to obtain an abortion. It was hoped that certain characteristics and relationships might emerge as a result of the study and that the findings would prove helpful in providing the best care possible to abortion patients.

The study was divided into the areas of primary, secondary and tertiary prevention since discussion with the Abortion Committee and a review of the literature seemed to indicate its importance in relation to abortion patients.

Data was collected over an eighteen month period, from December 1973 through June 1975, for 311 women who were given approval for an abortion. The women ranged in age from 14 through 48 years; 17 year olds were predominant in the sample. Approximately one-third of the abortion patients had never practiced contraception and 68% were not practicing contraception at the time of conception. However, 91% planned to use some method of birth control in the future.

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The findings of this project indicated that the following generalized statement could be made in regard to the abortion patients: they were likely to be single, under 20 years of age, living with their parents, were in grade 12 or under, had never used a contraceptive, were not practicing contraception at the time of conception but planned to do so in the future, requested pre and post abortion information, obtained the abortion by dilatation and curettage and vacuum and were seen by the hospital social worker.

It was further found that marital status and age had a great bearing upon the woman's use of contraception, upon her relationship with the father of the conceptus, and upon the support that she was receiving from him.

The author concluded that in the interest of the preventive model and social work intervention, there was a definite need for abortion counseling and family planning education. The counseling and educating could be appropriate for all women of child-bearing age, but the focus should be upon the early teenage group of women.
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CHAPTER I

PROBLEM FORMULATION

When a man and a woman have sexual intercourse without some form of a reliable method of birth control, they may be faced with a decision of whether or not to continue a pregnancy. They may decide to obtain an abortion.

Abortions have been obtained throughout the ages. However, in our culture, until recently, abortions have been associated with words such as illegal, backroom, dirty or hidden. "In ... previous years, it was practically synonymous with 'criminal' abortions and the 'therapeutic' (non-criminal) type was rarely discussed in public" (Ard, 1974, p.123).

Ard cited a case illustration of the difficulties faced by some young unmarried women when they become pregnant. Because the parents were afraid of what the neighbors might think, they insisted that their daughter have an abortion. When the daughter refused the abortion, she was sent away and was not to come back until she had "gotten rid of it." The young woman had a difficult pregnancy during which she was often hysterical and
frequently denied that she was pregnant. The daughter delivered her baby in a maternity home. It was in the maternity home that both the parents and their daughter began to receive professional help in regard to their problems and attitudes. The young woman decided to have her baby placed for adoption. (Ard, 1974, pp.126-127).

Perhaps the young woman would have been better off had she obtained an abortion early in her pregnancy. The researcher thinks that had the young woman received some form of prior counseling or therapy, or had she received a better sex education before she became pregnant, the ordeal for her might have been avoided. The researcher also believes that a woman's education should prepare her to take on responsibility for her own life and body.

Prevention Model

Before discussing the background of this abortion study or presenting the nature of the study, the prevention model, upon which this research is based, will be presented.

Social workers and other professional practitioners working with people and their problems share two aspects of intervention. One aspect is to seek solutions to problems and also to try and find effective means of treatment. The other aspect is for the professional practitioners to try and find ways to prevent the problems
from occurring.

The roots of preventive intervention began in the field of public health.

In public health the continuum of activities is called "primary prevention," "secondary prevention," and "tertiary prevention." These activities are often classified as "health promotion and specific protection," "early diagnosis and treatment (including case-finding)," and "disability limitation and rehabilitation." (Meyer, 1974, p.3)

As this study is primarily social work research but conducted in a medical setting with medical patients as the sample, this preventive model is most appropriate.

Rapoport offers the following definitions for the three levels of preventive intervention:

1. **Primary prevention** includes measures undertaken to obviate the development of disease in susceptible populations. It consists of health promotion, which includes all measures and institutions that enhance the general well-being of a population. Primary prevention also encompasses the concept of specific protection, which implies some knowledge of causation and consists in the health field of such measures as immunization, sanitation, sound nutrition, and so forth.

2. **Secondary prevention** generally encompasses case-finding, diagnosis, and treatment. The emphasis is on early diagnosis and treatment. While treatment specifically attends to the relief of distress, as conceived in terms of secondary prevention it seeks to shorten duration, reduce symptoms, limit sequelae, and minimize contagion.

3. **Tertiary prevention** is largely concerned with chronic or irreversible illness; the goals are limitation of disability resulting from the illness and promotion of rehabilitation measures. (Rapoport, 1961, pp.4-5)
For purposes of this study, the preceding aspects of preventive intervention in the practice of social work can be identified as follows:

1. Primary – education offered to a defined population.
3. Tertiary – prevent complications through education and prevent further incidence of the problem.

Social work sees the intervention as being presented along a time dimension or according to the extent of the pathological involvement. Crisis intervention has been the treatment model frequently used by the writer because it has been a useful approach to deal with specialized problems within the framework of preventive intervention. Crisis intervention has specific steps of intervention that would "keep something from happening" (Meyer, 1974, p.7).

**Researcher's Viewpoint**

The abortion issue is often in the center of legal and moral controversy. Abortion is a very personalized issue and this fact alone may account for the difference in the degree of individual opinions.
The researcher as a social worker thinks that abortion patients may develop problems directly related to the abortion. These problems may be of a practical nature, i.e., a baby sitter needed for the children in the home while the mother is hospitalized, or of a psychosocial nature. The presence or extent of the problems would of course depend upon the individual woman's maturity and circumstances. The researcher also thinks that counseling should not be mandatory but should be available and offered to all abortion patients.

The discussion of the study will be handled around prevention as the researcher thinks that it is in the total best interests of the woman to prevent the abortion from having to be performed. In terms of preventive intervention, the three levels of prevention would be the following:

1. Primary - to discuss ideas of prevention through education before the pregnancy or even intercourse has occurred.

2. Secondary - reaching women before they are past their twelfth week of pregnancy and no longer able to obtain an abortion by D and C and vacuum.

3. Tertiary - keeping emotional and physical factors that might arise from having obtained an abortion at a minimum.
A Review of the Literature

The reader might wonder how the researcher arrived at her emphasis on preventing the necessity of obtaining an abortion. This point of view developed through a review of the literature and the acceptance of some basic assumptions. The assumptions will be presented within the section of this chapter discussing the nature of the problem.

The first article, dealing with the abortion issue, that came to the researcher's attention at the very inception of the study was "Social Work Service to Abortion Patients" by Alice Ullmann (1972). The most significant conclusion, in accordance with the social worker's plans to begin counseling to the abortion patients, was that Ullmann made the assertion that the abortion patients had additional stress as the result of making the decision to have the abortion; and that efforts should be made to provide them with social work service. Ullmann's article was one with which the researcher readily identified. Then, a more thorough investigation began into a review of the literature. The areas that were closely looked at were: a general guide and overview to the abortion process; primary, secondary and tertiary prevention; staff reactions to abortion patients; family planning; and, social work views in respect to abortion.
A General Guide and Overview to the Abortion Process

Perhaps the best complete overview of the abortion issue is Daniel Callahan's *Abortion: Law, Choice and Morality*. He presents medical, psychiatric and fetal indications for abortion as well as medical sequelae and psychiatric consequences; a discussion in regard to legal policy is offered; and, moral implications are extensively discussed. The major focus is on the moral questions as they related to abortion. However, as stated by Callahan:

> These questions cannot be treated in isolation from medical, social and legal questions; they form a whole. (Callahan, 1972, p.12)

Eleanor Pelrine (1972) presents a Canadian overview on abortion. This book is written for the layperson who wants information about the current abortion situation or who might be contemplating obtaining an abortion. The researcher found that *The Right to Abortion* by the Group for the Advancement of Psychiatry, complements Pelrine's book. GAP provides professional viewpoints in an unbiased manner: in regard to taboos and misleading assumption; the obligation of motherhood; and, the rights of the woman and the unwanted child. (Group for the Advancement of Psychiatry, 1970)

*A General Guide to Abortion* by Bruce Sloane and Diana Horvitz support the writing of Pelrine and the GAP. Sloane and Horvitz present an overview in regard to
religious and legal considerations and developments as well as the medical aspects. (Sloane and Horvitz, 1973)

Primary Prevention.

Sloane and Horvitz, in addition to presenting an overview of abortion, offer a rationale for primary prevention in the form of counseling. The following statements are a summary of their thinking in this area. They suggest that most doctors are unable to give their patients an unbiased viewpoint. Abortion is not always a benign procedure, but neither is childbirth. A woman needs to know the risks, both physical and emotional, before she makes her decision. In particular, the single woman needs to weigh the pros and cons of obtaining an abortion and those of having her baby and keeping it. (Sloane and Horvitz, 1973; pp. 1-3)

A very practical and realistic approach to abortion counseling is offered in respect to nursing care in a volume of Clinical Obstetrics and Gynecology. The researcher thinks that these concepts can be considered the basis for abortion counseling by social workers as well. Those concepts are:

1. The need to orient patients to the elective abortion service and to the abortion procedure so that misconceptions can be eliminated; ...

2. Expedite total care by screening patients who need special services; ...
3. Present elective abortion in the context of family planning; ... and,

4. The need to make the patient's first contact with the hospital one that will establish a basis for trust and confidence in the health facility.... (Schaefer, 1971, pp.48-50)

The author also stressed that a postabortion clinic is an important part of total care.

John Asher felt that there are three principles involved in abortion counseling. Those principles are:

that "counseling be freely entered into;" that "counseling be supportive and non-judgmental regardless of the circumstances of the pregnancy;" and, that the abortion be "an educational experience" (Asher, 1972, p.686).

The preceding principles are well founded in light of some of the findings of a Canadian study by Joan Rogers and David Adams. They found that there were needs for:

(1) a comprehensive assessment of psychosocial problems,

(2) concerned health team members who can help the patient sort out her feelings and select a satisfactory solution to her problem,

(3) ongoing emotional support,

(4) availability of individual and family treatment resources either within the team or accessible to it,

(5) follow-up assessments, contraceptive counseling and follow-through by a caring individual who may well be in the patient's own community. (Rogers and Adams, 1973, p.79)

Current descriptive studies also come under the
heading of primary prevention since as a result of these studies a group is being identified. Tietze and Dawson (1972) collected data on legal abortions in eleven countries including statistics based on the observed levels of abortion by age, marital status and live births. Their data illustrates that the proportion of women under twenty years of age among all aborters has been increasing. This fact has been noted in all eleven of the studied countries. Abortion among unmarrieds has been increasing as well. In addition, the proportion of abortion patients with no (or only one) prior birth has also been increasing in countries with legal abortion. Tietze and Dawson remark that the:

apparently world wide and rapid increase in the rates of legal abortions among young women may reflect early maturation, changing patterns of sexual behavior and growing acceptance of abortion, as an alternative to forced motherhood. (van der Tak, 1974, p.98)

Paul MacKenzie and Linda Dawes' Canadian study in 1971 perceives the gathered data as illustrating that

"half the abortion patients were single and nearly one-third were below the age of 20 years . . . . Nearly two-thirds of the women seeking abortions admitted that they were using no contraception" (MacKenzie and Dawes, 1973, p.19)

Bracken and Swigar's (1972) study concerning the delay in seeking induced abortions, also contained
descriptive characteristics of the total sample of women who successfully applied for an induced abortion. Many of the research findings are in agreement with the study conducted by MacKenzie and Dawes, i.e. age distribution, marital status and contraception at the time of conception.

Secondary Prevention

A study was conducted by Marlene Hunter in West Vancouver, British Columbia and the data collected was directly related to the applications submitted for abortions. Her findings supported her assumption of the importance of secondary prevention: the desirability of patients presenting themselves early in their pregnancy; that more education should be provided for the very young woman; and that the concept of prevention rather than abortion should be emphasized. (Hunter, 1974, p.1092)

Bracken and Swigar point out the factors that are associated with delay in seeking induced abortions such as:

Younger women were more likely to apply after their tenth week of pregnancy; married women were significantly more likely to apply for an abortion early in pregnancy than were single women ...; women who had completed a higher level of education were less likely to apply for an abortion late in pregnancy ...; and, contraceptive users were less likely to delay in seeking an abortion than were non-users. (Bracken and Swigar, 1972, pp.303-305)

The authors perceived these findings to be most important as a delay in seeking an abortion involves
the risk of exposure to the more complicated procedures which are necessary for late pregnancy abortions, together with the potential for more serious psychological effects from these procedures. (Bracken and Swigar, 1972, pp.307-308)

Alternatives to abortion are also considered to be an aspect of secondary prevention. Alternatives to abortion are discussed in Sloane and Horvitz and by David Mace in his book, Abortion: The Agonizing Decision. However, the most conclusive list of suggestions, which should serve to reduce abortions, was provided by the Ottawa Children's Aid Society in a "Brief to the Board of Directors." Those suggestions are:

- immediate availability of counseling for women requesting an abortion;
- contraceptive education;
- sexual education and marital education;
- family planning research;
- public health programs;
- low premium life insurance effective at birth in the event of a defective child;
- abandoning all social prejudice against unwed mothers;
- anti-poverty programs;
- adoptive programs; and the like.

(Dehler, 1972, p.5)

The above suggestions serve a purpose if one is not pregnant. However, there was no discussion in the literature as to alternatives once one was pregnant.

**Tertiary Prevention**

One of the aims of tertiary prevention is to prevent further complications such as impaired mental health. As can be seen from the following discussion, there is a wealth of information available about the psychological
effects of the need to seek an abortion.

Addelson, after analyzing data from a three year study, found that even "those (abortion patients) with fairly well integrated egos, respond positively to social work efforts that provide an opportunity to ventilate anxiety and seek healthy solutions." (Addelson, 1975, p.823)

The evidence from the studies of Ford, Castelnuovo-Tedesco and Long (1971) and Meikle, Brody, Gerritse and Maslany (1973) point to the absence of psychological disturbance following an abortion other than perhaps a mild, temporary depression. Meikle, et al, were lead to the conclusion that

women with a history of relatively frequent psychosomatic problems are more likely to seek a therapeutic abortion. Since they have apparently in the past reacted to life stresses with a variety of somatic symptoms, they are likely to exaggerate this pattern with an unwanted pregnancy and to seek termination. (Meikle, et al., 1973, p.345)

Interesting results were deducted from the data in a Mount Sinai (New York) study (1966). Two of those findings were:

Those patients who were schizophrenic and neurotic prior to their pregnancies remained so after the abortion. However, the anxieties and depressions which arose as a direct result of the pregnancy were relieved; and, Abortion, performed in a hospital was found to be therapeutic in that it alleviated acute stages of depression and anxiety which had resulted from
becoming pregnant. (Adams, 1973, p.7)

**Family Planning**

Family planning could be considered under both primary and tertiary prevention. If abortion is considered a part of family planning, then it could come under the heading of secondary prevention as well.

In 1969, a section of the Criminal Code that banned the distribution of contraceptive information or materials was removed, thus paving the way for public family planning courses.

The use of contraceptive methods is an important indicator of the woman's motivation toward prevention of pregnancy. In a study conducted by Ford, et al., it was found that:

The majority of the women in both the abortion and control groups had adequate knowledge of, and resources for, contraception.... Many women in the abortion group had used no contraceptive method whatever or had used available methods haphazardly. (Ford, et al., 1971, p548)

Sullivan and Watt deduced that many of the young pregnant women had not used a contraceptive because their sexual activity was often impulsive; and, there was a fear of parental reaction to the use of contraceptives. Multiple social factors, values and belief systems, and certain religious concepts also influence the lack of contraception use. Sullivan and Watt's sample failed to
show a positive correlation between increased education and the use of contraceptive measures. "The hypothesis that increased education would increase the likelihood of the use of contraceptives was disproven in our sample" (Sullivan and Watt, 1975, p.82).

H. Grauer in "A Study of Contraception as Related to Multiple Unwanted Pregnancies," states:

The policy of the gynecology department at our hospital is to introduce women to and teach them the utilization of contraceptive methods following a therapeutic abortion. Despite these efforts contraceptive use did not increase between the first and subsequent abortions in the index group... the emotional problems these women have preclude an ability to utilize or accept contraceptive methods, are apparent. (Grauer, 1974,p.1084)

Staff Reactions to Abortion Patients

Staff reactions to abortion patients are important in all three areas of prevention intervention. Abortion arouses strong feelings because it is a matter of ethics which are very personal and vary in shade and intensity as much as people do. V. Haszeldine points out that it is the role of the hospital staff to save rather than destroy. (Haszeldine, 1974, p.39) However, Haszeldine articulates that the hospital staff must bear in mind that it is there to serve the patient. She feels the staff's feeling in regard to abortion is not the fault of the patient and that it is not the staff's job to pass moral judgment on others. (Haszeldine, 1974, p.40)
Existing studies indicate that both emotional conflicts and anxiety are present in many professionals involved in abortion work. One of the hypothesis of a study conducted by Marianne Such-Baer was that the "nurse's over-identification with the fetus and lack of identification with the aborting woman led to negative emotional reaction" (Such-Baer, 1974, p.435).

**Social Work Intervention**

As has been previously mentioned, social work intervention and prevention intervention go hand in hand.

Such-Baer provides two implications for social work practice:

Social workers who are involved in abortion work, feeling less discomforted, are in a strategic position to intervene and aid in alleviating the greater negative emotional reactions and anxieties of other professionals involved in abortion work, and,

If the social worker shared with other professional staff members the problems and feelings of the woman with an unwanted pregnancy undergoing an abortion, the identification with the fetus could be countered and an identification with the aborting woman could be fostered. (Such-Baer, 1974, p.44)

Frances Addelson, among others, points out the need for availability of professional social work for abortion patients who are experiencing emotional and social instability. (Addelson, 1971, p.988)

Crisis Intervention is an effective method of
social work for abortion counseling. Lydia Rapoport stated that there are three interrelated factors which produce a state of crisis:

(1) one or a series of hazardous events which pose some threat; (2) a threat to current or past instinctual needs which are symbolically linked to earlier threats that result in vulnerability or conflict; and (3) an inability to respond with adequate coping mechanism. (Roberts and Nee, 1971, p.277)

The situation of a woman obtaining an abortion could well fit into the preceding three categories. Crisis intervention theory states that the outcome of a crisis may well be in the direction of greater strength and mental health rather than in deterioration or pathology.

The crisis intervention approach is active, directive and authoritative, mainly because time limits are used for a framework. Problem-solving is conducted within a short period of time. Therefore, the treatment is primarily present-orientated with a strong focus on the here and now. (Roberts and Nee, 1971, p.297)

Therefore, in congruence with the treatment goals, the intervention involves the task of lowering tension and anxiety through reassurance, redefining and delimiting the problem and the focus on rapid mastery of that segment of the life experience. "Social workers are uniquely qualified by their training to play an essential and ongoing role in helping women with unwanted pregnancies meet this crisis" (Addelson, 1971, p.988).
Summary and Synthesis for the Review of the Literature

The major focus of this study was to collect quantitative-descriptive data in regard to women obtaining abortions. In addition to a general description, the study's focus was on what was seen as three major areas of prevention: (1) primary prevention; (2) secondary prevention; and, (3) tertiary prevention. It was necessary to review the literature and become aware of the makeup of the entire subject of abortion as part of the initiation of the study. A review of the literature dealt with a description of abortion patients and also with the abortion process and intervention with abortion patients.

The first section of the literature survey dealt with the abortion process. There are medical, psychiatric and fetal indications for abortion. It would appear that the moral questions cannot be treated in isolation from medical, social and legal questions. Several sources provided professional viewpoints in an unbiased manner. The obligations of motherhood and the rights of the woman and the unwanted child are offered for consideration.

The second section of reviewed literature dealt with primary prevention. It was suggested that most doctors are not able to give their patients an unbiased viewpoint and that a woman needs to weigh both sides of the abortion issue before deciding what to do. Through abortion counseling
the patient can be made aware of the abortion procedure; obtain special services that may be needed; and receive non-judgmental support.

The next area reviewed dealt with the abortion applicants and secondary prevention. The importance of early intervention was stressed. It became obvious through reading the literature that the very young woman required more education in the area of sexuality, and that the concept of prevention rather than abortion should be emphasized. It was found that the women who delayed in seeking medical advice in regard to a therapeutic abortion were young, single, had a low degree of education and were unlikely to have used a contraceptive method. These findings indicate that intervention with young women could be most helpful in terms of education and counseling.

There seemed to be a scant amount of literature dealing specifically with alternatives to abortion. The most inclusive literature was found in periodicals published by Children's Aid Societies. Contraceptive education and counseling, family planning research, low premium life insurance for the birth of a defective child and adoption programs were some of the alternatives suggested.

Descriptive studies have been conducted on an international as well as local scale. A fact noted in all the studies of this nature is that the proportion of women
under twenty years of age among all aborters has been increasing and that abortion among unmarrieds has been increasing as well.

There has been much discussion in the area of tertiary prevention, i.e. psychological concerns. The findings suggest that those women who were in good mental health prior to an abortion would return to the same healthy state following an abortion, although they might experience a mild, temporary depression. It is suggested that these women would respond positively to social work efforts. Patients who were severely neurotic or schizophrenic prior to their pregnancies remained in this state of mental health after the abortion. It appears that severely negative mental conditions usually do not occur because of the abortion. However, existing fear, stress and anxiety can be diminished through social work intervention.

Family planning studies previously referred to suggest that the majority of women seeking abortions have had an adequate knowledge of contraception but do not make use of these methods. Social factors and personal values have influenced the lack of contraception use.

Another section of literature reviewed was that pertaining to staff reactions to abortion patients. Because the role of the hospital staff is to save rather than destroy, the staff may experience negative or mixed reactions to
women obtaining abortions. Current studies indicate that
the same health professionals involved in abortion work do
feel negatively about abortion. They are urged to serve
the patient and to refrain from passing moral judgment on
the woman obtaining an abortion.

The final section of literature reviewed dealt with
social work intervention. There are two main areas of
opportunity for social work intervention, with the abortion
patient and with the professional staff. Crisis inter-
vention is an effective method of social work with abortion
patients as it deals with a crisis in one's life and deals
mainly with the immediate problem in the here and now.
Problem solving can usually be conducted in a short period
of time and the groundwork can be laid for more counseling
or intensive therapy if it is needed. The emphasis with
the staff would be education in regard to the patient and
her abortion procedure. Through consultation or group
sessions, the staff could be given assistance to express
and work through their negative emotional reactions.

Having reviewed the literature dealing with abortion,
brief overviews of the abortion legislation and controversy
will now be presented to further describe the abortion
situation.
A Brief Overview of Abortion Legislation

In order that the entire abortion process and its complexities might be better understood, a brief overview of abortion legislation is now offered.

The current Canadian legislation on abortion is found in Section 237 of the Criminal Code. Before the amendments were passed, abortion for any reason was illegal under the Criminal Code. Currently, abortions are illegal except under the following circumstances:

The abortion must be performed by a qualified medical practitioner in an accredited or approved hospital; the practitioner must first receive a certificate in writing from the therapeutic abortion committee of that hospital, stating that the continuation of the patient's pregnancy "would or would be likely to endanger her life or health"; the therapeutic abortion committee must consist of not less than three members, each of whom must be a qualified medical practitioner; and the practitioner performing the operation cannot sit on the committee. (Pelrine, 1971, p.32)

As a health matter, abortion comes under provincial jurisdiction but because the termination of fetal life is involved, the criminal aspects are included in the Federal Criminal Code. (Family Planning Division Fact Sheet, 1974)

The Criminal Code does not offer a definition for the word "health" and the Criminal Code allows hospitals not to perform abortions if they so choose. This means that abortions (and sterilizations) are not carried out in most of the Roman Catholic hospitals as the Church
regards abortion as homicide. Also many small hospitals
do not perform abortions as they have not set up abortion
committees. For this reason many larger hospitals are then
placed in the position of performing more abortions, often
resulting in a shortage of beds.

The term "health" creates a great deal of contro-
versy. The interpretation in some hospitals might refer
to the physical health of the mother; and, another hospital
might feel that "health" refers to both physical and mental
health of the pregnant woman. The Oxford English Dictionary's
definition of health is "soundness of body." The World
Health Organization Charter refers to the term health as
meaning "a state of complete physical, mental, and social
well-being." (Felrime, 1972, p.52) David Dehler, an Ottawa
lawyer, asserts that

the recent interpretation of the Supreme Court
of Canada of the Bill of Rights upholds the
principle that any new federal law has to be
construed in the light of the fundamental rights
expressed in the Bill of Rights (i.e., the right
to life, due process of law; etc.) and that the
recent abortion amendments to the Criminal Code
are a denial of these rights. (Dehler, 1972, p.6)

The current controversy in regard to the legal
considerations of abortion is that some Canadians want
abortion removed from the Criminal Code. This group of
citizens thinks, however, that abortions should not be
performed by anyone other than qualified physicians in an
accredited facility, and that this consideration should remain in the Criminal Code. The Canadians who hold the opposite view assert that Section 251 should adhere strictly to the letter as they maintain that the term "health" is too broadly interpreted. It is felt that much of the legal debate in regard to abortion is a result of the religious and moral values of those individuals involved in the legal process.

A Brief Overview of the Abortion Controversy

Aspects of the existing legal situation in regard to abortion have been briefly presented. The author would now like to expand the discussion of the controversy into the areas of religious, moral and social complexities as they pertain to Canadian abortions.

Most of the arguments stem from the question of when life begins. Roman Catholic doctrine asserts that the soul enters the embryo at the moment of conception; therefore, life is destroyed when abortion occurs. This doctrine was adopted in 1969. (Sloane, 1971, p.8) Non-Catholics think that Catholics do not need the law to support their moral principles and such religious beliefs should not be imposed by law on those who do not hold them. (Sloane, 1971, p.11)

Most other religious groups, Jews, Buddhists, Shintoists and Mohammedans do not share the Catholic view on abortion. Adherents of the Anglican and United Churches in Canada are divided.
United Church Moderator Robert McClure had this to say:

"So many ethical and moral questions are very complex ... I conclude that the greatest sin to face in this matter is to bring into the world an unwanted child. Abortion is only needed as a breakdown to birth control. Abortion is to an obstetrician what amputation is to an orthopedic surgeon. One regrets that they ever have to be done at all. When they have to be done – do them."
(Pelrine, 1972, p.49)

Jewish liberalism springs from a Biblical and historic tradition in which abortion was rarely legislated against and a theology which considers the unborn fetus a part of its mother's body until it breathes independently. (Sloane, 1971, p.10)

The American Baptist Church has taken the lead in expressing the Protestant, liberal point of view favoring abortion on request during the first three months of gestation and upon medical indication through the rest of the pregnancy. The Unitarian Church has taken a most liberal view (1968) by leaving the decision entirely up to the patient and the physician. (Sloane, 1971, p.12)

Daniel Callahan in his book, Abortion: Law, Choice and Morality, devotes much of his writing to the moral issues of abortion. He points out that those who view abortion as murder would naturally favor restrictive laws, and would exclude most of the commonly proposed indications for abortion. Likewise, those who do not view abortion as murder would favor more permissive laws, and would consider
a broad range of indications for abortion.

The bias of the moral policy implies the need for moral rules which seek to preserve life. But, as a policy which leaves room for choice rather than entailing a fixed set of rules - it is open to flexible interpretation when the circumstances point to the wisdom of taking exception to the normal ordering of the rules in particular cases .... One would be deciding that, for the preservation or furtherance of other values or rights-species-rights, person-rights-a choice in favor of abortion would be serving the sanctity of life. (Callahan, 1972, p.501)

The third area that enters into the abortion controversy is that of social concerns. This area is one in which mores and attitudes have an impact on our individual decisions. If women had a choice, they might not only consider what is legal as related to abortion but would base part of their decision upon what they saw as being socially acceptable. (Callahan, 1972, p.502) In The Right to Abortion: A Psychiatric View by the Group for the Advancement of Psychiatry, the view is taken that a woman should have the right to abort or not just as she has the right to marry or not. The basis for this view lies in the GAP belief that "nothing can be more destructive to a child's spirit than being unwanted and there are few things more destructive to a woman's spirit than being forced without love or need into motherhood. (Group for the Advancement of Psychiatry, 1970, p.49)

Abortion should also be viewed in relation to the
society in which it is taking place, i.e. in underdeveloped
countries or areas of poverty, obtaining an abortion can be
attributed to a desperation not to have a child impossible
to support. If social conditions, which seemingly could
be changed, force many women to consider and choose abortion,
then perhaps abortion laws would not have to be changed."

Despite strong feelings pro and con, characteristic as they are of political, ethical and
religious convictions, the practice of abortion
has played an important role in the limitation
of family size and the elimination of unwanted
babies in every corner of the globe throughout
the history of industrial and pre-industrial
societies. (Sloane, 1971, p.4)

**Nature of the Problem**

A descriptive study of women approved for abortions
in a general hospital was chosen as an area of study for
the following reasons:

1. The researcher was a social worker in a
hospital where abortions were being performed;

2. The women were obtaining abortions because
their pregnancies were unwanted;

3. Many of the women obtaining abortions wanted
to avoid having an unwanted pregnancy in the future;

4. The researcher desired to obtain a better
understanding of this group of women for her professional
practice which would of course be shared with other
concerned health professionals, i.e. physicians and
nurses; and,

5. The researcher desired to become as helpful as possible to this group of women in respect to their own values and philosophies of life.

Current Abortion Legislation

Before continuing with the development of the study, it is important that one be aware of the current legislation upon which the abortion process is based.

The Abortion Bill was passed in the Canadian House of Commons on May 14, 1969 and became effective as law on August 28, 1969. It was passed with a struggle and to the present date, there continues to be much conflict and discussion concerning the issue. The Act provides: that the individual hospital has the choice whether or not to have abortions performed in its institution. In order to perform abortions a hospital must adhere to the following: (a) a hospital must have an abortion committee consisting of at least three physicians none of whom perform abortions themselves; and (b) there must be a majority decision by the abortion committee as to whether the individual abortion requests are accepted or rejected.

The regulations and thoughts about abortion legislature are frequently in a state of change and there are many different opinions as to how this service should be
offered and whether or not abortion should remain in the Criminal Code. The interpretations of the term "health" differs from hospital to hospital and the application of the law is inconsistent from hospital to hospital. (Pelrine, 1972, p.38)

Abortion Committee Query

The Abortion Committee of a general hospital thought that the teenagers and women requesting abortions might have some problems in coping with an abortion. Studies conducted in other hospitals by Cheetham (1974); Dauber and Goldstein (1972); Gedan (1974); and, Margolis, Davison, Hanson, Loos and Mikkelsen (1971), supported the Abortion Committee's supposition. Therefore, the Abortion Committee requested that the abortion patients receive counseling by a social worker. The social worker then became an "invited", non-voting member of the Abortion Committee.

Social Work Intervention

Permission was obtained from the physicians of the abortion patients to begin intervention with the women after they were admitted to the hospital to obtain their abortions. Through counseling the abortion patients upon admission, the social worker made the following observations:

1. Some patients were anxious as they had no knowledge as to which abortion procedure would be performed,
and they were concerned as to whether they would be
"awake" or "asleep" during the procedure;

2. Several young girls were not aware that a
parent or guardian would have to sign the surgical
permission form;

3. Many patients became upset upon learning that
they would have to remain in the hospital when they had
made no arrangements to do so;

4. The families of a few of the patients first
learned of their daughters' pregnancies when they saw the
wording on the surgical permission form; and,

5. The abortion patients seemed to feel relieved
of some worry and anxiety after discussing their pregnancy
and desire for an abortion with the social worker.

An assumption that the social worker held was that
the abortion itself was not the real issue with an abortion
patient; rather, that the pregnancy was unwanted and as a
result the abortion was requested. In the various studies
conducted by Clark, Pone, Forstner and Tredgold (1968);
Ebon (1971); Rogers and Adams (1973); and, Newton, Brotman,
McEdward and Owens (1973) this view was supported. The
author of this study, as a social worker, felt the need to
discover some characteristics and facts about this group
of women in order to enable the health team to maximize its
effectiveness when dealing with the abortion patients.
The Request for a Study

The Abortion Committee wanted and had a need to know more about the women for whom they were making important decisions. They had no personal contact with the patients other than through the referral letters. The Abortion Committee members recognized that any surgery or medical procedure carries a certain amount of risk, and that it is considered a possible surgical risk if a general anesthetic is used. Therefore, the Abortion Committee members felt that a patient would more likely be in a better state of physical health if an abortion could be avoided. Studies by Brody (1971); Callahan (1972); and Sullivan and Watt (1975) uphold this view.

Some of the questions that the Abortion Committee was asking were:

1. Who were these women; what were their age and marital status?
2. Had the abortion patients had previous pregnancies?
3. Did the abortion patients have children presently living with them?
4. Had the patients ever used a contraceptive?
5. Had the women been practicing some method of contraception when they became pregnant?
6. Had the abortion patients had any previous abortions?
The Abortion Approval Procedure

The steps for obtaining an abortion were as follows:

1. The presence of a pregnancy must be confirmed.
2. The woman requesting an abortion must obtain two referral letters from two different physicians; one from the physician who would perform the abortion and the other from a psychiatrist, family physician, gynecologist or some other concerned physician.
3. The referrals would then be submitted to the Abortion Committee of the hospital in which the abortion would be performed.
4. The Abortion Committee would consider the request and arrive at a decision.
5. If the application was approved, the operating room would be notified that an abortion could be scheduled for the individual concerned.
6. The physician would notify his patient of the Abortion Committee's decision.

As a result of the social worker's suggestion, the Abortion Committee recommended that all the patients who were to be considered for a therapeutic abortion at the hospital should be interviewed by the social worker. In turn, the social worker would submit a report of the initial
interview which would accompany the physician's referral letters to the Abortion Committee.

The Hospital Board of Management, which is the hospital policy making body, decided that it should not be mandatory that every abortion patient be interviewed by the social worker, such an interview should be strongly encouraged.

Following the Board of Management's policy in regard to the social work service, a new program was initiated. Through the physicians' offices or with the individual prospective patients, interviews were arranged. It was then possible for the patient to be seen three times by the social worker: (1) prior to hospital admission; (2) upon hospital admission; and (3) before discharge from the hospital.

Because abortions were being performed on a regular basis and the frequency of requests was increasing, the Abortion Committee desired to learn more about the women who were requesting abortions. This study was initiated as a result of the Abortion Committee's request for some statistical type of information about the patients who were accepted for abortions.

The Commencement of the Study

As implied in the discussion thus far, the major focus of the project was to discover more information about
the women receiving abortions at a general hospital. The author hoped that through the study, some definite characteristics could be obtained in order to provide descriptive information concerning this group of women. It was also hoped by the Abortion Committee and the social worker that through the findings of the study, a future social work and medical program could be developed to meet the needs of this population of women.

As the author was the only social worker for the hospital, all the abortion patients were brought to her attention for counseling. She was given access to all the medical records and correspondence pertaining to the abortion patients. Therefore, the data collection process could be fairly complete as both counseling and research could be accomplished simultaneously.

Initially an open-ended questionnaire was considered and used on a trial basis. It became clear however, that this method would absorb too much recording time and make tabulation difficult. A close-ended questionnaire was then designed with the intent of tabulating each variable independently and then making cross tabulations with several variable combinations. Thus by including such variables as age, marital status, contraceptive practice, father of the conceptus and length of gestation, a search for variable relationships could be made. Speculations about the
determinants then might be drawn from the discovered relationships.

A decision was made that the researcher would fill out the questionnaire as the process progressed from the initial interview to the patient's discharge from the hospital. The questionnaire and format for the study were presented to both the Abortion Committee and the hospital administration. Permission was received to proceed with the project.

The concerns of this study as developed from a review of the literature and professional experience, have come from three aspects of prevention: primary, secondary and tertiary. In direct relation to these three areas of prevention are three assumptions. According to Lillian Ripple: "an assumption is a proposition that is taken as given in the particular investigation." (Ripple, 1960, p.35) The assumptions in this study are those concerning variables relevant to the subject matter. These variables are not being tested in this research but have been investigated in the research of others. The author is therefore, accepting the following three assumptions: (1) The abortion itself is not the real issue with an abortion patient; rather that the pregnancy is unwanted and as a result, the abortion is requested; (2) A patient would more likely be in a better state of health if an abortion could be avoided, since
any surgery or medical procedure involving an anesthetic carries a certain amount of risk; and, (3) Teenagers and women requesting abortions usually have problems of a psychosocial nature.

The researcher also has accepted two additional assumptions which pertain to the entire concept of prevention as discussed in this study. Those assumptions are: (1) Notwithstanding current and past values of society, sexual activity will continue to occur both within and without the marital relationship, and occasionally it will lead to unwanted pregnancies; and, (2) It is preferable to prevent conception rather than obtaining an abortion following conception.

Questions Formulated Around the Three Areas of Prevention

It was thought that the following questions should be considered as a means of describing the area of primary prevention in regard to those women receiving abortions:

1. Is there a need to provide contraceptive counseling?

2. What were the circumstances as to why the patient conceived and was a contraceptive used?

3. If the patient has never practiced contraception, why not?
4. What is the patient's contraceptive plans after the abortion has been obtained?

The concern in regard to secondary prevention grew out of the assumptions that the risk to the patient's health would be less if an acceptable alternative to the abortion could be found that the sooner the abortion is performed, the less surgical risk there would be. The following questions were then considered:

1. Has the patient received other help?
2. With whom has she discussed having an abortion?
3. Have alternatives to the abortion been considered and if so, why have they been rejected?
4. Is the patient aware of the abortion procedure that will be performed and the possible side-effects or complications?
5. When did the patient first seek medical guidance?
6. What was the time involvement from the beginning of the process until the abortion was obtained?

The possible negative effects of the abortion upon the patient's mental health was one of the main concerns of the study. In the interest of tertiary prevention, it was felt that answers to the following questions might help to describe areas where there might be potential problems for the patient:
1. What personal involvement will the patient have with the father of the conceptus after the abortion?
2. Who will be aware of the patient's abortion?
3. Has the patient received support in making her decision to have an abortion?
4. How much time and guidance did the patient have to make the decision to obtain an abortion?
5. How important is it that the "secret" of the abortion be kept?
6. Does the patient have any personal or family problems with which she would like to receive help?
7. Has or would the patient desire to talk to a competent person in regard to her feelings, problems or concerns in relation to her decision to obtain an abortion?

In direct relation to the area of mental health, which would be considered tertiary prevention, it is suggested that the following factors might serve to mitigate anxieties or fears of the patient around the abortion procedure:

1. Establishing a rapport between the social worker and patient for the basis of future counseling.
2. The answering of questions relating to the abortion procedures; and
3. Discussing other concerns or problems that the patient might have.

An Overview of the Research Design

The research design used in this project was one of a quantitative-descriptive nature with the emphasis on population description rather than hypothesis testing, program evaluation or a study of variable relationships. According to Samuel Finestone and Alfred J. Kahn in Polansky's Social Work Research, the general purpose of a descriptive study is:

to describe the characteristics of a population or phenomenon when the characteristics of interest are shown.

There are no prior hypotheses about casual relationships between variables, or testing of such relationships. However, there may be simultaneous consideration of two or more variables for more precise description.
The design requires carefully defined population and representative samples .... Data may be gathered from questionnaires, interviews, observation or available statistical reports. Such studies are usually ends in themselves (policy planning, administration) but also generate hypotheses. (Polansky, 1975, p.62)

Perhaps Tripodi, Fellin and Meyer give a somewhat broader definition when they state:

Quantitative-descriptive studies are empirical research investigations which have as their major purpose the delineation or assessment of characteristics of phenomena, program evaluation, or the
isolation of key variables. These studies may use formal methods of approximations to experimental design with features of statistical reliability and control to provide evidence for the testing of hypotheses. All of these studies use quantitative devices for systematically collecting data from populations, programs, or samples of populations or programs. They employ personal interviews, mailed questionnaires, and/or other rigorous data gathering devices and survey sampling procedures. (Tripodi, Fellin, Meyer, 1969, p.38)

The author of the study intended to use every woman that was accepted for an abortion at a general hospital over an eighteen month period of time as the sample. The project was not designed to test explicit hypotheses about women being accepted to obtain abortions, but rather to answer some questions and to describe a population. As the study was used to relate variables, it falls in agreement with the above, (Tripodi, et al, 1969), and with the Finestone and Kahn (Polansky, 1975) definition of a quantitative descriptive study which has as its emphasis the obtaining of a population description.

As already stated, no hypotheses will be stated for the purpose of this study although when the study is completed some hypotheses may be formulated. According to Selltiz, Jahoda, Deutsch and Cook:

A hypothesis may assert that something is the case in a given instance, that a particular object, person, situation or event has a certain characteristic... and, that the role of hypotheses in scientific research is to suggest explanations
for certain facts and to guide in the investigation of others. (Selltiz, et al., 1959, p.35)

**Concept Definitions**

It is important to the understanding of this study to be aware of the concepts that the researcher was using. It is necessary to clarify concepts so that the ideas that affect the study will be clear. Ripple states: "The term concept is used in two senses: It may mean the word or words, that is, the verbal symbol that stands for an idea, or it may mean the idea itself." (Ripple, 1960, p.41)

The concepts used in this study are as follows:

**Abortion:** The expulsion of a fetus before it is viable.

In this definition, the fetus is the developing offspring. Viability is a stage of development outside the uterus. (Family Planning Division, Abortion Fact Sheet) As the term is used in this study, it will be referring to a therapeutic abortion.

The three abortion procedures are:

**D & C and Vacuum Aspiration:** This medical term refers to an abortion procedure performed under a general anesthetic where the cervix is opened; the fetus and placenta are removed through the vaginal canal; and, suction is applied to ensure that the uterus is free of fetal and placental tissue. This
procedure is generally used only up to the gestation period of twelve weeks.

Hysterotomy: A hysterotomy is a major operation performed under a general anesthetic. An incision is made in the abdominal and uterine walls through which the fetus and placenta are removed. This abortion procedure is usually used when a pregnancy is too advanced for an urea induction or D & C and Vacuum Aspiration and is similar to a cesarean section.

Urea Induction: A urea induction is an abortion procedure performed under a local anesthetic when the gestation has reached approximately fourteen to sixteen weeks. Some of the amniotic fluid is withdrawn and replaced with another hormone based fluid. The fetus is affected by the solution and contractions begin. The fetus and placenta are passed through the vaginal canal, usually within thirty-six hours.

Alternative to Abortion: This concept refers to considering some other choice than or substitute to an abortion.

Contraceptive: A means or obstacle employed to prevent the fertilization of an ovum by a sperm.

Gestation: This term refers to the length of the pregnancy in terms of days, weeks or months commencing from conception.
Health: This concept, as interpreted by the Abortion Committee, refers to the World Health Organization definition of health: "a state of complete physical, mental, and social well-being." (Felzine, 1972, p. 52)

Health Team: Those professionals in the hospital setting working together to meet the needs of the patients, i.e., psychiatrist, social worker, registered nurse, nurse's aide, physician.

Patients: Those women who are admitted or soon to be admitted to the hospital in order that they might obtain an abortion.

Researched Hospital: The general hospital where the study was conducted.

Therapeutic Abortion: A therapeutic abortion is a legally induced abortion that is performed when the continuation of the pregnancy would or would be likely to threaten the mother's health or life. (Family Planning Division, Abortion Fact Sheet, 1970)

Tubal Ligation: This term will be used to mean a sterilization procedure involving the fallopian tubes. It is recognized that more precise medical terms designate the type of procedure, such as a bilateral salpingectomy or vaginal salpingectomy.

The Setting of the Study

This study was undertaken at a general hospital in
Windsor, Ontario, Canada. Windsor is a city with a population of approximately 200,000 residents. Windsor is situated in the southwest corner of Ontario and is separated from Detroit, Michigan in the United States by the Detroit River. There are no major Canadian cities in close physical proximity to Windsor.

Windsor is located in the County of Essex in which there is a large farming population. Essex County and Windsor have a varied ethnic representation: Chinese, Mid-European, French-Canadian, Negro and other cultural entities. There is also a wide variety of religious denominations with a large proportion of Roman Catholics.

The population of Windsor has largely been a working class population as Windsor's economy has been greatly dependent upon the automotive industry. A sizeable proportion of Windsor's work force has been employed in the various automotive-related industries. Windsor, it could be said, is an industrial city surrounded by a rural environment.

The study was conducted in a general hospital established and particularly exhibiting an atmosphere of warmth and concern. The hospital is of a medium bed size and has been in existence for approximately fifty years.

The Social Service Department of the hospital has been in existence for only a few years. In accordance
with the hospital organizational chart, the Social Service Department is directly supervised by the Assistant Administrator who is in charge of patient care.

The role of the Social Service Department, as stated in the Social Service Policy, is as follows:

The Social Service Department is an auxiliary service functioning under the auspices of ... Hospital and upholds and supports the policies defined by the hospital administration. The role of the Social Service Department is to provide an administrative unit in the hospital organization within which and from which social workers are able to carry out their professional duties in co-operation with other personnel. The place of the Social Service Department in the organizational structure thus enables planning, co-ordination and supervision of social work and social workers in the hospital.

At this time it might be well to conclude this area of discussion with the list of the objectives and functions of the Social Service Department since it was with these concerns in mind that a service was established for women obtaining abortions within the hospital.

- To give the entire health team a better understanding of the patient in relation to his social and emotional environment.

- To help the patient and his family accept the illness and residual physical disability.

- To assist the patient and his family with problems precipitated by the illness.

- To encourage optimum utilization of medical care.

- To help the individual achieve his fullest capacities.
To encourage and participate through the professional organization new resources for unmet social needs.

To participate in studies which will contribute toward improved patient care and health programs in the community.

To participate in studies to enhance or further develop one's professional attributes and goals.

To participate in appropriate education, training and orientation programs.

Summary to Chapter I

The nature of the study was to focus on discovering information about the women obtaining abortions in a Windsor, Ontario general hospital. It was also the intent to relate some of the variables in order that some possible relationships might be discovered.

Along with a general description of the sample, primary, secondary and tertiary prevention were the emphasis of the study based on a review of the literature and professional experience.

Chapter I contained the discussion of the problem formulation from the identification of the problem to the commencement of the study. Chapter II will present the details of the research design.
CHAPTER II

METHODOLOGY

Research design is described by Kahn and Finestone as dealing with a plan developed to answer a question, describe a situation or test a hypothesis. In other words, it deals with the rationale by which a specific set of procedures, which include both data collection and analysis, are expected to meet the particular requirements of a study. (Kahn and Finestone, 1960, p.48) Selltiz, et al states:

Research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. (Selltiz, et al., 1959, p.50)

This chapter presents the following sections: the research concerns and questions, the population and sample, the method of data analysis and the limitations of the design.

In light of the two preceding definitions of research design, it was planned to follow a descriptive study research design with the following three purposes of descriptive research in mind:

1. To formulate a problem for more precise investigation;
2. To increase the investigator's familiarity with the phenomenon to be investigated; and,

3. To clarify concepts; gather information about practical possibilities for carrying out research in real-life settings; and provide a census of problems regarded as urgent by people working in a given field of social relations. (Selltiz, et al., 1959, p.51)

It is planned to have this study continue into more areas of need and concern of the abortion patient which will be discovered as a result of this current research project.

Research Concerns and Questions

The purpose of this research project was to describe a population of abortion patients in a general hospital. There was an emphasis on the following three areas of prevention: (1) primary prevention, (2) secondary prevention, and (3) tertiary prevention. Although the preceding areas were ones which the researcher wanted to study, it appeared that contingent upon these aspects of prevention were several research questions that needed to be examined.

A. Primary Prevention

As discussed in Chapter I, it is thought that family planning with the use of contraception, prevents
the need for abortion. A review of the literature had suggested that a woman's religious affiliation, age, educational level and marital status might determine whether or not contraception was practiced. There was also a supposition that the amount of sexual activity and the desire to prevent an unwanted pregnancy would influence the practice of birth control. In this regard, the following questions were asked:

1. Was there a significant relationship between a woman's religious affiliation and contraceptive use?

2. Was there a significant relationship between the amount of sexual activity (prior to conception) that the woman had experienced and whether or not contraception was practiced?

3. Was there a significant relationship between the woman's age and whether or not contraception was practiced?

4. Would a patient change her contraceptive use so that an unwanted pregnancy in the future might be prevented?

5. Was there a significant relationship between the woman's completed educational level and the use of a contraceptive method?

6. Was there any significant relationship between
the use of contraception and the woman's marital status?

B. Secondary Prevention

A review of the literature indicated that there are definite physical risks or side-effects of abortion. There is a direct correlation between the length of gestation and the likelihood of side-effects resulting from the abortion procedure. The sooner the abortion is performed, the less likely surgical risks may occur. Childbirth carries some risks as does abortion, but generally speaking, there is not the additional risk associated with a general anesthetic. In this regard, the following questions were asked:

1. Had the patient received any guidance in regard to an alternative to the abortion?
2. Was there a significant relationship between the length of the application period and the type of abortion procedure performed?
3. Was there a significant relationship between the woman's use of a contraceptive and whether or not she had had a previous therapeutic abortion?
4. Was there a significant relationship between the type of abortion the woman was told she
would have and the abortion procedure actually performed?

5. Had the women received pre-operative and post-operative information relating to their abortion procedure and their physical health?

6. Was there a significant relationship between the woman's age and when she first sought medical advice?

C. Tertiary Prevention

It was theorized in a review of the literature that the majority of women do not suffer long term psychological disturbances as a result of an abortion but, possible guilt feelings and other anxieties may develop immediately after an abortion and continue for several weeks. To further identify the women who might benefit from tertiary prevention and social work intervention, the following questions were asked:

1. If the woman was living with her parents, had she told them of her abortion plans?

2. Was there a significant relationship between the father of the conceptus and whether or not he had knowledge of the pregnancy?

3. Did the patient need reassurance in regard to her abortion plans and if so, was she seen by the social worker?
4. Was there a significant relationship between the woman's age and the support received from the father of the conceptus?

The Research Sample

As the research project coincided with the offering of a casework counseling service to all the abortion patients in the researched hospital, all of these patients constituted the sample for the time period of the study. The researcher was able to obtain data in regard to all the patients. However, because the researcher personally interviewed only 187 patients, some observations were not available.

Although the entire abortion patient population during an eighteen month period of time was chosen for this study, the group was considered as being a sample rather than a population. For purposes of this study, the population was considered as consisting of all the women receiving abortions at the researched hospital, in the past, present and in the future.

Experts on surveys state that a sample is a group of subjects selected from a larger group and including less than all the subjects in that larger group. (Kahn and Finestone, 1960, p.93)

Therefore, sampling procedures would make it possible to secure information about a large number of subjects without studying all of them. The usual limits of time and
financial resources upon a student researcher usually preclude any examination of the total population. The reader is then reminded that the results of the study may limit its generalizations to a specific hospital in Windsor, Ontario.

Method of Data Collection

Descriptive studies are not limited to any one method of data collection. The researcher incorporated a review of the literature, observations, interviews, documents and statistical records as a means of securing data. When selecting the data gathering instruments, the researcher kept in mind the fact that the data collecting instruments must be planned carefully as the aim was to obtain complete and accurate information.

During a pretesting period, the researcher first attempted to use an interview schedule and recorded some answers in the patients' presence. This method was time consuming to record and difficult to code and analyze. Most importantly however, the data collecting seemed to detract from the counseling which was of prime importance. Through a review of the literature, conversations with concerned health professionals, personal observations of the three abortion procedures and the pretesting period, a master coded response form was formulated. The form was
filled out after contact with each patient was concluded. The interview, physicians' referral letters, the patients' medical charts and the social worker's insight were all used as sources of information.

In keeping with the confidentiality aspect of social work, no names of the individual patients were stated on the response form. A number was assigned to each case to facilitate keeping an accurate count of the sample.

The master coded response form was of a fixed-alternative nature. The various areas were presented to the patient in an open-ended manner to encourage the freedom of expression. The variables on the form fell under the following four areas:

1. General, basic information;
2. Primary prevention;
3. Secondary prevention;

While conducting the interviews, with an interview schedule in mind, the following principles were considered:

1. The interviewer should not interject his own attitudes or experiences into the conversation or express value judgments...
2. Because any sequence of questions structures the subject matter, the interview schedule should have the minimum number of questions in the simplest form adaptable to the problem.
3. The response which can be anticipated from a question is often quite different from the logical compliment of the question ....

4. All interview schedules and questions should always entail certain unpredictable effects.

5. The attitude of the interviewer toward the respondent should always be extremely attentive and concentrated ...

6. The expert interviewer is much more than a recording device. No matter what the form of the interview, he should pursue his questioning to the point where no significant ambiguities exist for him. (Caplow, 1956, p.167)

The researcher was mindful throughout the interview that the patient's concerns were of first importance and the research concerns were second. The interview period was used to discuss the patient's own personal concerns, information was offered as to the patient's hospitalization and abortion procedure, guidance was offered in regard to contraception and, research data was collected.

Method of Data Analysis

The researcher expected that the data collection would show a quantitative description of the different variables. A computer was used as the vehicle for the data analysis. The master coded response forms were filled out by the researcher. Computer cards were then punched and verified.
Frequency distributions were used first in analyzing the data as they are brief, explicit and quickly reveal all the information contained in the original unordered lists. To illustrate this information, histograms were used for some of the variables.

Nominal scales were used to help describe the data. The mode was used for simple summaries because as one had "recorded a large number of observations on a nominally scaled variable, some simple summary of the whole distribution is often useful." (Freeman, 1965, p.38)

One of the main tasks of statistics is to help describe the relatedness or association between variables. The variables in this study were cross-tabulated and chi square was used for statistical analysis and the .05 level of significance was used. Cramer's V or phi was then used to describe the strength of the association.

Limitations of the Research Design

There were several limitations of the research design. First, there were 311 women involved in the study, but the researcher actually only interviewed 187 patients. Thus there were some missing observations. Secondly, perhaps it might have been more meaningful for the patients themselves to answer a questionnaire rather than the researcher's doing so. Therefore there was the possibility
that the researcher might have misinterpreted the patient's responses. More patient participation might be an area for future research.

Lastly, there was a bias in the design as the variable descriptions were confined to those pre-selected by the researcher. It should be kept in mind, however, that a review of the literature and discussions with interested health professionals was conducted to eliminate as much bias as possible.

Summary

The research design for this study was of a quantitative-descriptive nature. After a review of the literature, observations, interviews and a pretest, a pre-coded master response form was designed to be completed by the researcher. Additional data was gathered from documents and statistics.

A computer was used to tabulate the data and to calculate some of the statistics. Frequency distributions, Cramer's V and phi were used to analyze the data.

Chapters I and II have presented the problem formulation, review of the literature and the research design for this study concerning abortion patients in a general hospital. The following chapter, Chapter III, will present an analysis of the data.
CHAPTER III

AN ANALYSIS OF THE DATA

The analysis of the research data will be presented in four sections. The first section, A, of this chapter will be devoted to a general account of the sample which will be described relative to its compositions of the characteristics, age, residence, religious affiliation, marital status, contraceptive practice, abortion procedure, the time involved in obtaining the abortion, and the patient contact with the hospital social worker. The remaining sections of this chapter will present data for the purpose of providing the answers to the research questions which have been discussed in Chapter II. Sections B, C and D will discuss the research questions relating respectively, to primary, secondary and tertiary prevention.

Section A: Description of the Sample

Age:

The sample was made up of 311 women whose ages ranged from 14 through 48 years. Table 1 provides the frequency and percentages of the women's age groups.
TABLE 1. --Age: Frequency and percentage

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 and over</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>40 - 45</td>
<td>16</td>
<td>5.1%</td>
</tr>
<tr>
<td>35 - 39</td>
<td>23</td>
<td>7.4%</td>
</tr>
<tr>
<td>30 - 34</td>
<td>28</td>
<td>9.0%</td>
</tr>
<tr>
<td>25 - 29</td>
<td>58</td>
<td>18.6%</td>
</tr>
<tr>
<td>20 - 24</td>
<td>72</td>
<td>23.2%</td>
</tr>
<tr>
<td>15 - 19</td>
<td>109</td>
<td>35.0%</td>
</tr>
<tr>
<td>10 - 14</td>
<td>2</td>
<td>0.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>311</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The largest age bracket was represented by the teens, of which there were 111 (36%) women. The second largest group of women were those in their early twenties, comprising 72 (23%) of the sample. Thus, almost 60% of the women obtaining abortions were between the ages of 14 and 24. The age range of 25 - 29 contained 58 (18.6%) women. The remaining 70 (22.5%) abortion patients ranged in age from 30 - 48 years.

Because the percentage was so high in the 14 - 19 age range, it was felt that a further examination would
be more beneficial in determining possible areas of concern or need. Figure 1 denotes the breakdown of the entire age range. It can be readily seen that the 17 year olds, of which there were 33, have obtained the greatest number of abortions. This figure represents 11% of the total sample or 29% of the 14 - 19 years of age group.

Area of Residence:

As shown in Table 2, there were 238 (76.5%) women who were living in the city of Windsor and they represented the largest segment of the sample.

TABLE 2. -- Residence Area Showing Frequency and Percentage

<table>
<thead>
<tr>
<th>Residence</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Windsor</td>
<td>238</td>
<td>75.5%</td>
</tr>
<tr>
<td>Essex County</td>
<td>55</td>
<td>17.7%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>5.8%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>311</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

These statistics are realistically indicative of the area mainly served by the researched hospital which is primarily Greater Windsor and the County of Essex.
FIGURE 1: Age Distribution of Abortion Patients

Frequency:

Age:
14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42-43 44 45 46 47 48
Religious Affiliation:

As pointed out in the earlier discussion in regard to the abortion controversy, there is a distinct division of thought between Roman Catholics and non-Roman Catholics. The reader should also be cautioned that a high proportion of Roman Catholics might be coming to the researched hospital because the Roman Catholic hospital in Windsor does not perform abortions or sterilization procedures. It should be noted that there is a high percentage of Roman Catholics in Essex County or at least many people who give their religious preference as Roman Catholic. Therefore, there may have been many more Roman Catholics simply because they constitute a greater percentage of the population. Table 3 illustrates the population distribution between the two faiths as well as a comparison between the census of Essex County and of the researched hospital.

As can be seen in Table 3, there is a statistically significant difference of religious affiliation between the hospital abortion patients and the women of Essex County. The reader is cautioned that the Essex County census includes women of all ages whereas the sample contains basically young women. The Goodness of Fit test with a chi-square of 75.43 indicated a difference in the relationship. The researched hospital did have a higher representation of abortion patients from categories "Other Protestant"
and "non-Christian." An explanation for this difference might be that some of the patients, as a result of guilt or embarrassment, did not want to acknowledge their religious affiliation.

TABLE 3. --Percentage Comparison of Religious Affiliation of Women Between the 1971 Census for Essex County Area and the Abortion Patients in the Researched Hospital

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Hospital Sample</th>
<th>Essex County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>46.3%</td>
<td>51.1%</td>
</tr>
<tr>
<td>Protestant:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglican</td>
<td>12.3</td>
<td>13.2</td>
</tr>
<tr>
<td>United</td>
<td>9.5</td>
<td>15.3</td>
</tr>
<tr>
<td>Baptist</td>
<td>5.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Lutheran</td>
<td>1.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Other Prot.</td>
<td>17.8</td>
<td>10.7</td>
</tr>
<tr>
<td>Non-Christian&lt;sup&gt;a&lt;/sup&gt;</td>
<td>7.1</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<sup>a</sup> Included non-Christian denominations, atheists and agnostics.

Goodness of Fit Test

\[ \chi^2 = 75.43 \quad df = 6 \quad P < 0.001 \]
Marital status:

The marital status of the women obtaining abortions is illustrated in Table 4. It is of interest to note that 95 (30.5%) women were married or living in a common-law relationship while 216 (69.5%) were not living in a marital relationship. Thus far it can be seen that the abortion patients were primarily young, unmarried women.

TABLE 4. -- The Marital Status of Women Accepted for Abortions: Showing Frequency and Percentage

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>174</td>
<td>55.9%</td>
</tr>
<tr>
<td>Married(^a)</td>
<td>95</td>
<td>30.5%</td>
</tr>
<tr>
<td>Separated</td>
<td>25</td>
<td>8.0%</td>
</tr>
<tr>
<td>Divorced</td>
<td>14</td>
<td>4.5%</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>311</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

\(^a\) Includes Common-law Relationships

Contraception Practice:

Contraception practice at this time is illustrated in Table 5 in terms of use prior to conception, at the time of conception, and contraception plans for the future.
TABLE 5. --Contraception Use by Abortion Patients Showing Percentage

<table>
<thead>
<tr>
<th>Contraceptive Use</th>
<th>Prior to Conception</th>
<th>At time of Conception</th>
<th>Plans for Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>36.3%</td>
<td>67.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>63.7%</td>
<td>32.1%</td>
<td>91.2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0% (n=278)</td>
<td>100.0% (n=293)</td>
<td>100.0% (n=238)</td>
</tr>
</tbody>
</table>

One of the assumptions of this study is that an abortion is requested because, for one reason or another, the pregnancy is unwanted. From the family planning point of view, it may be important to note that according to Table 5, 36.3% of the women had never practiced contraception and 63.7% were not practicing contraception at the time of conception. Perhaps of more pertinence is the fact that 8.8% of the women who did not plan to practice contraception after obtaining the abortion ranged in the age from 15 through 29 years and were single.

Abortion Procedure:

Table 6 related to the frequency of the three different forms of abortion procedures. The impact of
these procedures as they relate to other variables will be discussed later in the chapter.

TABLE 6. --Abortion Procedures as Arranged for 311 Patients Showing Frequency and Percentage

<table>
<thead>
<tr>
<th>Abortion Procedure</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>D &amp; C and Vacuum</td>
<td>254</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urea Induction</td>
<td>36</td>
<td>11.5</td>
</tr>
<tr>
<td>Hysterotomy</td>
<td>21</td>
<td>6.8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>311</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

As can be seen by looking at Table 6, 81.7% of the abortions were performed by D & C and Vacuum. This abortion procedure is considered to carry the least amount of risk for the patient. Later in the chapter this variable will again be discussed as it relates to secondary prevention. That is, preventing the need to obtain urea induction or hysterotomy which are abortion procedures that carry higher risks.

**Waiting Period:**

The waiting period refers to the time (in terms of gestation weeks) when the patient first sought medical advice to the time the abortion was performed. Since
referral letters, stating the length of gestation, were received for all the patients, this source of information was then used for calculating the waiting time involved from contact with the first referring physician until the abortion was actually performed. Later in the chapter, the relationship between this time or waiting period and the various abortion procedures will be discussed.

The mode for contact with the first referral physician was 6 gestation weeks and for the performance of the abortion was 10 gestation weeks. Therefore, it may be assumed that the waiting period for the majority of the women was four weeks. However, after the waiting period was calculated for each individual, it was established that for 155 (50%) patients, the waiting period was only two weeks.

Referral to the Social Worker:

The variable "social work contact" is of utmost importance as an indicator of the social work service offered and as a means of data collection. Table 7 illustrates when social work contact was made and the reasons for non-contact.

The social worker counseled and interviewed 187 (60.1%) abortion patients. Of the 124 (39.9%) women not seen by the social worker, 80 (24.1%) were missed because
the social worker had no knowledge that the patient had been admitted or that the abortion was being performed at that particular time. This omission was largely due to a communication problem at the commencement of the study between the hospital admitting department, surgical booking personnel, and the social worker.

TABLE 7. --Social Work Contact Showing Points of Referral and Reasons for Non-Contact Illustrated with Percentages

<table>
<thead>
<tr>
<th>Patients Seen</th>
<th>60.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-hospital</td>
<td>32.8%</td>
</tr>
<tr>
<td>Hospital arrival</td>
<td>26.0</td>
</tr>
<tr>
<td>Post-operative</td>
<td>1.3</td>
</tr>
<tr>
<td>Patients Not Seen</td>
<td>39.9%</td>
</tr>
<tr>
<td>Social worker had no knowledge abortion was scheduled</td>
<td>24.1%</td>
</tr>
<tr>
<td>Social worker not available</td>
<td>8.4</td>
</tr>
<tr>
<td>Patient cancelled abortion</td>
<td>4.8</td>
</tr>
<tr>
<td>Language barrier</td>
<td>1.9</td>
</tr>
<tr>
<td>Patient refused to see social worker</td>
<td>0.7</td>
</tr>
</tbody>
</table>

TOTAL 100.0% (n=311)
In this first section of the data analysis, the author has attempted to provide the reader with a breakdown of the population relative to certain selected characteristics. Sections B, C and D, which follow, will deal with data analysis as related to the research questions.

Section B: Data Pertaining to Primary Prevention

In this section of the paper, the presented data will answer the research questions in the area of primary prevention. It is thought that family planning, with the use of contraception, prevents the need for abortion. "If one equated contraception with prevention, abortion then becomes the cure for an unwanted pregnancy" (Sullivan and Watt, 1976, p.79). In the light of the preceding quotation, abortion can be accepted as a solution to unwanted pregnancy in the case of contraceptive failure or as an alternative to contraceptive methods. As discussed in Section A of this chapter, 33% of the women obtaining abortions had never practiced birth control and at the time of conception, 67.9% were not attempting to use some contraceptive method. The goal of the study in the area of primary prevention, i.e. family planning, was to determine characteristics of the women obtaining abortions in order that the medical and social work staff might gain
insight and a better understanding of women who are obtaining abortions. In turn, perhaps more effective means of family planning, education and implementation might be developed as a means of preventing the need for an abortion.

B. Question 1: Religion and Contraception

The review of the literature had suggested that a woman's religious affiliation might determine the use or non-use of contraceptives. Therefore, the first research questions asked:

Was there a significant relationship between a woman's religious affiliation and contraceptive use?

In order that this first question might be answered, the two variables, contraception prior to conception and religious affiliation, were cross tabulated. These two variables are illustrated in Table 8. Because the Roman Catholic Church takes a definite stand against the use of contraceptive methods, it was decided to group the religious denominations into two categories, Roman Catholic and non-Roman Catholic.

The chi-square statistic indicates that there was a statistically significant relationship between religious affiliation and contraception prior to conception; however, the association was low with a Cramer's V of .20. Roman Catholics are less apt to have used some form of contraception
i.e. less pill, less IUD, than women of other faiths. It should be noted that the Roman Catholic women were more frequent users of the rhythm method than the rest of the women. The rhythm method is accepted by the Roman Catholic Church as a method of birth control. However, this method is not very reliable.

TABLE 8. --Abortion Patients' Religious Affiliation and Contraceptive Use Prior to Conception Illustrated by Percentages

<table>
<thead>
<tr>
<th>Contraception Prior to Conception</th>
<th>Roman Catholic</th>
<th>Non-Roman Catholic</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>44.4%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Pill</td>
<td>34.1</td>
<td>49.3</td>
</tr>
<tr>
<td>Condom</td>
<td>7.1</td>
<td>5.3</td>
</tr>
<tr>
<td>Rhythm</td>
<td>6.4</td>
<td>0.7</td>
</tr>
<tr>
<td>IUD</td>
<td>3.2</td>
<td>7.6</td>
</tr>
<tr>
<td>Other</td>
<td>4.8</td>
<td>6.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0% (n=126)</td>
<td>100.0% (n=132)</td>
</tr>
</tbody>
</table>

Missing Observations = 53

\[ \chi^2 = 15.88 \quad df = 5 \quad P < .01 \]

Cramer's \( V = .20 \)
Table 9 provides more data for the research question in terms of religious affiliation and the use of contraception at the time of conception and future plans for contraception.

TABLE 9. --Religious Affiliation and Contraception: Prior to Conception, at Conception and Future Plans for Contraception Illustrated With Chi Square and Cramer’s V

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>df</th>
<th>P</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious Affiliation and Contraception Prior to Conception</td>
<td>74.92</td>
<td>49</td>
<td>.01</td>
<td>.20</td>
</tr>
<tr>
<td>Religious Affiliation and Contraception at Conception</td>
<td>64.78</td>
<td>49</td>
<td>.06</td>
<td>.18</td>
</tr>
<tr>
<td>Religious Affiliation and Future Plans for Contraception</td>
<td>33.83</td>
<td>28</td>
<td>.20</td>
<td>.19</td>
</tr>
</tbody>
</table>

Statistics based on raw data.

As indicated in Table 8, in regard to religious affiliation and contraception prior to conception, Table 9 indicates that there is a relationship but that the association is slight. There is no relationship between religious affiliation and contraception at the time of conception and religious affiliation and future plans for conception. The reasons for no relationship may be because
few people were using contraceptives at the time of conception and because most people plan to practice contraception in the future.

B. Question 2: Abortion Patient's Sexual Activity and Contraception Practice Prior to Conception

It would seem that sexual activity, marital or non-marital, is a definite social indication of the need for the consideration of family planning methods in respect to preventing unwanted pregnancies. Therefore, the second research question asked:

Was there a significant relationship between the amount of sexual activity (prior to conception) that the woman had experienced and whether or not contraception was practiced?

Table 10 illustrates sexual activity, prior to conception, in relation to the use or non-use of a contraceptive.

There was a significant relationship between the amount of sexual activity that the woman had experienced and whether or not contraception was practiced. There was a moderate strength of association indicating that those women who were more sexually active, 6 months or more, were more likely to be using a contraceptive. There were 84 women who had been having intercourse for 5 months or less. Of this number, 61 or 72.6% had never used any form of contraception. In terms of family planning
education, the data would seem to indicate that it is the women who are beginning to become sexually active who need to be reached.

TABLE 10. --The Amount of Sexual Activity, Prior to Conception and Contraceptive Use Illustrated by Percentage

<table>
<thead>
<tr>
<th>Amount of Sexual Activity</th>
<th>Contraceptive Use</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Some a</td>
</tr>
<tr>
<td>1 year &amp; over</td>
<td>12.4%</td>
<td>87.6%</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>41.7</td>
<td>58.3</td>
</tr>
<tr>
<td>4 - 5 months</td>
<td>58.1</td>
<td>41.9</td>
</tr>
<tr>
<td>2 - 4 times</td>
<td>81.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Once</td>
<td>94.7</td>
<td>5.3</td>
</tr>
</tbody>
</table>

a The rhythm method is included
Missing observations = 50

$\chi^2 = 96.52 \quad df = 4 \quad P = \leq 0.01 \quad$ Cramer's $V = .61$

Before concluding the discussion in regard to sexual activity, it would be beneficial to discover who the less sexually active women are in order that they might be identified as candidates for family planning education. Table 11 illustrated the data in terms of sexual activity and age.

It can be seen in Table 11 that the less sexually
active women, those that have been active for five months or less, are under the age of 29, but the largest population is found in the teen group. Once again it is emphasized that the teenage women would be the target population which is in need of receiving family planning education.

**TABLE 11. --The Amount of Sexual Activity, Prior to Conception Cross-tabulated by the Patient's Age Illustrated by Frequency**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Sexual Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 4 times</td>
</tr>
<tr>
<td>40 - 48</td>
<td>0</td>
</tr>
<tr>
<td>35 - 39</td>
<td>0</td>
</tr>
<tr>
<td>30 - 34</td>
<td>0</td>
</tr>
<tr>
<td>25 - 29</td>
<td>3</td>
</tr>
<tr>
<td>20 - 24</td>
<td>5</td>
</tr>
<tr>
<td>14 - 19</td>
<td>34</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

Missing observations = 24

\[ \chi^2 = 133.26 \quad df = 10 \quad P < .001 \]

Cramer's V = .48
B. Question 3: The Relationship Between the Age of the Abortion Patient and Contraceptive Use

The following quotation stresses the necessity for providing adolescents with adequate sexual knowledge.

The adolescent's lack of contraceptive knowledge has been well documented. Even when some knowledge has been gained, such as that from peers, it is often erroneous. If the teenager's knowledge of contraception is to be increased, myths and misapprehensions must be taken into account and corrected. (Gordon, 1973, p.51)

To further investigate family planning, in addition to contraceptive use and sexual activity, the third research question asked:

Was there a significant relationship between the woman's age and whether or not contraception was practiced?

Table 12 indicates that the older the woman the more likely she was to have practiced some method of contraception, both prior to conception and at the time of conception. Cramer's V indicated a moderate association of .51 between age and contraceptive use prior to conception and a low association of .31 between age and contraceptive use at the time of conception.

Again, in the interest of teenagers and family planning, it is of value to note that although all the age ranges contained women who had never practiced some form of contraception, the teens had the greatest concentration: 67%. In terms of misinformation, several young,
teenaged girls expressed to the social worker that they believed women could not get pregnant the first time that they engaged in sexual intercourse or if the sexual act was not completed.

B. Question 4: Future Practice of Contraception

As discussed in Chapter I, future contraception practice (after the abortion) was one of the topics of discussion between the social worker and the abortion patients. Effective family planning counseling would have to consider the woman's motivation and wishes in this regard. Thus, the fourth research question asked:

Would a patient change her contraceptive use so that a future unwanted pregnancy might be prevented?

Table 13 illustrates, in tabular form, some of the data relating to past and future contraceptive use. As can be seen in Table 13, there were approximately 9% of all the women obtaining abortions who did not plan to use any form of contraception after their abortion. Twelve of the 21 women were in the teen-age range. These women stated either that they believed birth control methods were not "natural" or that they did not plan to continue to be involved sexually. It is noted that approximately 35% of the women, in addition to an abortion, underwent a sterilization procedure.
TABLE 12. --Age and Contraception Illustrated by Frequency

<table>
<thead>
<tr>
<th>Age Ranges</th>
<th>Contraception Prior to Conception</th>
<th>Contraception at Conception</th>
<th>Contraception Plans for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Some</td>
<td>TOTAL</td>
</tr>
<tr>
<td>40 – 48</td>
<td>2</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>35 – 39</td>
<td>2</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>30 – 34</td>
<td>2</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>25 – 29</td>
<td>9</td>
<td>.43</td>
<td>52</td>
</tr>
<tr>
<td>20 – 24</td>
<td>15</td>
<td>50</td>
<td>65</td>
</tr>
<tr>
<td>14 – 19</td>
<td>71</td>
<td>35</td>
<td>106</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>177</td>
<td>.278</td>
</tr>
</tbody>
</table>

Missing observations = 3
\[ \chi^2 = 71.61 \; df = 5 \]
\[ p < .001 \]
Cramer's V = .51

Missing observations = 18
\[ \chi^2 = 27.37 \; df = 5 \]
\[ p < .001 \]
Cramer's V = .31

Missing observations = 73
\[ \chi^2 = 13.53 \; df = 5 \]
\[ p < .05 \]
Cramer's V = .24
This action would indicate a strong desire to avoid future unwanted pregnancies and the completion of reproductive functioning or the completion of the family size.

**TABLE 13.** --Contraception Use Prior to Conception and Future Contraception Plans Illustrated by Frequency and Percentage

<table>
<thead>
<tr>
<th>Contraception Prior to Conception</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>101</td>
<td>36.3%</td>
</tr>
<tr>
<td>Some</td>
<td>177</td>
<td>63.7%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>278</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plans for Future Contraception</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>21</td>
<td>89.8%</td>
</tr>
<tr>
<td>Some</td>
<td>134</td>
<td>56.3%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>83</td>
<td>34.9%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>238</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

A further representation of this data may be seen in Tables 14 and 15. Table 14 illustrates that of the 36.3% (101) women who had never practiced contraception, see Table 13, 17.3% (13) would continue non-practice. With the exception of 5.3%, the majority of the women who had
used some contraceptive in the past would continue to do so in the future. According to Table 14, 21.9% women did not plan to practice contraception in the future.

TABLE 14. --Contraceptive Use Prior to Conception and Future Plans for Contraception Illustrated by Percentage

<table>
<thead>
<tr>
<th>Contraception Prior to Conception</th>
<th>None</th>
<th>Some</th>
<th>Sterilization</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>17.3%</td>
<td>73.3%</td>
<td>9.3%</td>
<td>99.9% (n=75)</td>
</tr>
<tr>
<td>Some</td>
<td>5.3</td>
<td>52.0%</td>
<td>42.7%</td>
<td>100.0% (n=150)</td>
</tr>
</tbody>
</table>

Missing observations = 86

\[ \chi^2 = 29.17 \quad df = 2 \quad P < .01 \quad \text{Cramer's } V = .36 \]

One might suspect that since the young women are the ones who have not practiced birth control, they would naturally not want sterilization. Table 15 shows that this supposition is basically true. There was only one teenager who underwent sterilization. It may be concluded therefore, that either a contraceptive method would be practiced, (or planned to be practiced), or a sterilization procedure would be obtained by a large majority (90.9%) of the women after their abortion had been obtained.
TABLE 15. Abortion Patients' Age Range Cross-Tabulated by Those Patients Obtaining a Sterilization Procedure Illustrated by Frequency

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency of Sterilization Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 - 48</td>
<td>17</td>
</tr>
<tr>
<td>35 - 39</td>
<td>18</td>
</tr>
<tr>
<td>30 - 34</td>
<td>19</td>
</tr>
<tr>
<td>25 - 29</td>
<td>21</td>
</tr>
<tr>
<td>20 - 24</td>
<td>7</td>
</tr>
<tr>
<td>14 - 19</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>85</strong></td>
</tr>
</tbody>
</table>

B. Question 5: Education and Contraception

In a Canadian study by Sullivan and Watt (1975), the hypothesis that increased education would increase the likelihood of the use of contraceptives was disproven. There was no explanation for this phenomena. In determining the effectiveness of family planning as related to achieved education levels, the fifth research question asked:

Was there a significant relationship between the woman's completed educational level and the use of a contraceptive method?

Table 16 points out that there was a direct
correlation between the years of obtained schooling and contraceptive use.

Based on the raw data, Chi-square was 24.08 with 13 degrees of freedom and $P < .05$. There was a significant relationship but the association was low with a Cramer's $V$ of .35. Thus, the more years of schooling that women had obtained, the more apt they were to be using some method of contraception.

TABLE 16. Women Who Have Completed Their Education Correlated by the Years of Their Completed Education Level and Contraceptive Use Prior to Conception Illustrated by Percentage

<table>
<thead>
<tr>
<th>Completed Grade Level</th>
<th>Contraception Prior to Conception</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Some</td>
</tr>
<tr>
<td>17 and up</td>
<td>16.6%</td>
<td>83.4%</td>
</tr>
<tr>
<td>14 - 16</td>
<td>20.7%</td>
<td>79.3%</td>
</tr>
<tr>
<td>13 and under</td>
<td>47.3%</td>
<td>52.7%</td>
</tr>
</tbody>
</table>

Statistics based on the raw data.
Missing observations = 100

$X^2 = 24.08$  $df = 13$  $P < .05$
Cramer's $V = .35$

In Section I of this Chapter, it was noted that the mode for those accepted to obtain abortions was in the age
range of 14 - 19 years. Thus, it was decided to enlarge upon the fifth research question by cross tabulating contraceptive use by the grade level of those patients currently in school. Table 17 illustrates this data.

The observations of Table 16 also pertain to Table 17. The higher the level of education, the more likely that the patient would have practiced some form of contraception. In the interest of family planning, it should be noted that those students in grades 12 and under have a high incidence of non-contraceptive use and perhaps there needs to be more thorough family planning education for these grades. The reader is cautioned however, that there is a previous relationship with age probably being the underlying factor for the grade level.

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>Contraceptive Use Prior to Conception</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Some</td>
</tr>
<tr>
<td>14 - 19</td>
<td>35.9%</td>
<td>65.3%</td>
</tr>
<tr>
<td>13</td>
<td>57.1</td>
<td>42.9</td>
</tr>
<tr>
<td>11 - 12</td>
<td>63.3</td>
<td>36.7</td>
</tr>
<tr>
<td>9 - 10</td>
<td>88.6</td>
<td>13.4</td>
</tr>
<tr>
<td>8</td>
<td>80.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>
B. Question 6: Marital Status and Contraception

It would seem that people frequently think that therapeutic abortion patients are most likely to be single and have made little use of contraception. The sixth research question asked:

Was there any significant relationship between the use of contraception and the woman's marital status?

Table 18 which illustrated the data for this query, indicated that all the divorced and widowed women, and close to 90% of the married and separated women had practiced some form of contraception prior to conception. However, this statement holds true for less than 50% of the single women. As far as future contraceptive use was concerned, the percentages are closer together, but the married women had the highest percentage, 100.0%, had intentions to practice some form of birth control after the abortion was obtained. Table 18 implies that marital status does have an influence upon the use of contraceptives. A Cramer's V of .46 indicates a moderate association between marital status and contraceptive use prior to conception. At the time of conception, marital status still had a direct bearing, although the association was low, on the use of contraception with 53.6% of the married women and only 23.1% of the single women attempting to make use of some form of birth control. There was a
slight association, Cramer's V equaled .13, between marital status and the use of contraception planned for the future.

Summary for Section B

As mentioned in Chapter I, one of the major assumptions of the study was that the abortion was not the real issue with an abortion patient; rather that the pregnancy was unwanted and as a result the abortion was requested. Therefore, Section B dealt with the area of primary prevention with an emphasis upon family planning.

There was a search for variable relationships to discover some characteristics and facts about this group of women in order to enable the interested health team to maximize its effectiveness when dealing with the abortion patients.

One of the questions, relating to family planning, raised in the problem formulation asked who the patients were who had not been practicing contraception. Several observations or descriptions such as religious affiliation, age and marital status can be drawn from the data.

A woman's religious affiliation had a direct bearing upon the use of contraception with non-Roman Catholics more apt to have used a contraceptive prior to conception and at the time of conception than Roman Catholics.
TABLE 18. --Abortion Patient's Marital Status and the Practice of Contraception Illustrated with Percentage

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>&quot;Some&quot; Contraception Practiced</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior to Conception</td>
<td>At Time of Conception</td>
<td>Future Plans</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>45.5% (n=165)</td>
<td>23.1% (n=39)</td>
<td>85.2% (n=121)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>89.5% (n=76)</td>
<td>53.6% (n=45)</td>
<td>100.0% (n=84)</td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>85.7% (n=21)</td>
<td>25.0% (n=6)</td>
<td>90.0% (n=20)</td>
<td></td>
</tr>
<tr>
<td>Previously Marrieda</td>
<td>100.0% (n=16)</td>
<td>30.8% (n=4)</td>
<td>92.3% (n=13)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>63.7% (n=278)</td>
<td>32.1% (n=293)</td>
<td>91.2% (n=238)</td>
<td></td>
</tr>
</tbody>
</table>

Missing observations = 33, 18, 73

$\chi^2 = 59.07$ df = 3  
$\chi^2 = 28.65$ df = 3  
$\chi^2 = 3.013$

$P < .001$  
$P < .001$  
$P$ ns

Cramer's $\nu = .46$  
Cramer's $\nu = .31$  
Cramer's $\nu = .13$

*a* Included divorced and widowed
The strength of association was low. There was no significant relationship as far as future contraceptive plans were concerned. All the women except 8.8% had either undergone a sterilization procedure or stated that they planned to practice some form of contraception after obtaining their abortion. However, it is not known if these plans were actually implemented.

Age was also a significant factor in the use of contraception. Although all the age ranges contained women who had never practiced contraception, the greatest concentration was with the teens (14 - 19) of whom 67% had never used a contraceptive. Several factors might contribute to this observation such as, insufficient family planning education, reluctance to seek medical advice due to feelings of guilt or embarrassment, or a lack of knowledge about one's own sexuality.

In addition to religious affiliation and age, marital status also played a major role in the practice of contraception. Approximately 90% of all the married women had practiced contraception but only 50% of the single women had done so. At the time of conception, 53.6% of the married women but only 23.1% of the single women were using a contraceptive. As far as future contraception was concerned, all the married women and all but 14.8% of the single women planned to use some form of birth control.
It should be first observed that although some women were practicing contraception at the time of conception, nevertheless, a pregnancy occurred. The failure might have been due to the type of contraceptive being unreliable or improperly used. Because many single women had never practiced contraception in the past or at the time of conception, it is thought that perhaps there was reluctance to purchase a contraceptive due to embarrassment or guilt because the woman was not married. Another possibility is that a contraceptive was not used because intercourse was unexpected or unplanned.

Thus far then, an analysis of the data indicates that teenage, single women, engaging in sexual intercourse are prime candidates for seeking abortions. If, going back to the assumption stated at the beginning of the summary, unwanted pregnancy and abortion is to be avoided, this group of women would need to be presented with effective family planning counseling.

In respect to the implementation of family planning information, schools and family counseling agencies would be excellent places to reach likely candidates for abortion.

An examination of the research results showed a significant relationship between the women's completed level of education and the practice of contraception. Of those women still in school, ranging from 8 to 19
(post-graduate) years, a great number of women in grades 12 and under, with an emphasis on grades 8 through 10, had never practiced contraception. Age was an underlying factor where grade level was concerned.

As stated in Chapter I, there was query as to what were the circumstances, in regard to the incidence of intercourse, as to why the patient conceived. There were six women who stated that they had been raped (two cases reported and four unreported); presumably the rest of the women had been willing participants in the sexual episode. The data also pointed out that the longer the period of time in which sexual activity occurred, the more likely she was to have practiced contraception. There were 84 women who had been experiencing intercourse for 5 months or less and of the number, 72% (61) had never used any form of contraception. This group of 61 women were also 29 years of age and under, with approximately 78% in their teens. Again, it would seem that teenage girls need to be reached with family planning education although they may be relatively inactive sexually.

In the interest of primary prevention in the form of family planning, it may then be concluded that women who are seeking abortions do share some general characteristics. If abortions are to be avoided, then medical and counseling professionals need to reach the women who
are likely to obtain abortions. First, it must be stated that approximately one-third of the patients had never practiced contraception and about 68% were not practicing contraception at the time of conception. In the interest of prevention, the women to be reached with family planning counseling are in their teens, attending school in grades 8 through 12, are single, relatively sexually inactive and are Roman Catholic.

There are more characteristics of women who have been accepted to obtain an abortion, which need to be examined in order to obtain a clearer and more meaningful picture of who these women are. This additional information will be provided in Sections C and D.

Section C: Data Pertaining to Secondary Prevention

A review of the literature indicated that there are definite physical risks or side-effects of abortion. Various studies present substantiating data at varying degrees of seriousness. The risks could directly affect the woman physically, i.e. hemorrhage, sterility, pelvic inflammatory disease or create hazzards in regard to future pregnancies.

The concern in regard to secondary prevention with the abortion patient grew out of the assumptions that the risk to the patient's health would be less if an acceptable alternative to the abortion could be found and that the
sooner the abortion is performed, the less surgical risk there might be. Thus, in this section of the data analysis, data will be presented to answer the research questions in regard to screening high risk groups and early case finding.

C. Question 1: Advice in Regard to Abortion Alternatives Received by Abortion Patients

When considering the possible risks of abortion, it might be to a woman's advantage to consider alternatives to abortion that would carry an all-over lower incidence of risks. Thus the first research question pertaining to this area of research asked:

Had the patient received any guidance in regard to an alternative to the abortion?

Table 19 shows that 31.2% of the physicians suggested that their patients obtain abortions while 65.2% suggested that their patients carry their pregnancies to term.

The physicians further offered alternatives of caring for the baby. It was noted that the mode for this variable relating to alternatives was that of carrying the pregnancy to term and placing the baby for adoption.
TABLE 19. Alternatives to Abortion as Suggested by the Patients' Physicians Illustrated with Frequency and Percentage

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Carry pregnancy and keep baby</td>
<td>94</td>
<td>42.0%</td>
</tr>
<tr>
<td>2) Have abortion</td>
<td>70</td>
<td>31.3%</td>
</tr>
<tr>
<td>3) Have baby and place for adoption</td>
<td>51</td>
<td>22.6%</td>
</tr>
<tr>
<td>4) No specific advice</td>
<td>8</td>
<td>3.6%</td>
</tr>
<tr>
<td>5) Have baby and place temporarily</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>224</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

C. Question 2: Length of Application Period and the Abortion Procedure Performed

It is recognized that in order to keep morbidity from abortion at an acceptable level, the abortions should be performed within the first trimester (up to the twelfth week of gestation). To facilitate the occurrence of this belief, it is necessary that delay in interviewing the patient and arranging for the abortion be minimal. The second research question then asked:

Was there a significant relationship between the length of the application period and the type of abortion procedure performed?

As was stated in Section I of this chapter, the
application period for the majority of women (50%) was two
weeks. However, 22% of the women waited four weeks from
the time that they saw their first referring physician
until the abortion was performed. Thus, if a woman was close
to the twelfth week of pregnancy when she saw her first
physician and at that time was a candidate for an abortion
by D & C and Vacuum; by having to wait another two to four
weeks, she would probably have to undergo an urea induction
instead.

Table 20 points out the time frequencies of the
waiting period. Although the mode was a waiting period of
two weeks, it is conceivable that any of the patients
waiting for six weeks or more might obtain their abortion
by a procedure other than the one originally possible at
the time of the first physician referral.

C. Question 3: Previous Therapeutic Abortions and
Contraception

It might be hypothesized that women who had
obtained abortions and accepted the possible physical
risks would make a greater effort to prevent future
unwanted pregnancies. In the interest of avoiding another
surgical procedure, the third research question asked:

Was there a significant relationship between the
woman's use of a contraceptive and whether or not
she had had a previous therapeutic abortion?
TABLE 20. --Length of the Application Period Illustrated by Frequency and Percentage

<table>
<thead>
<tr>
<th>Waiting Period In Weeks</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>4.3</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>4</td>
<td>68</td>
<td>22.3</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
<td>7.9</td>
</tr>
<tr>
<td>2</td>
<td>155</td>
<td>50.8</td>
</tr>
<tr>
<td>1</td>
<td>14</td>
<td>4.6</td>
</tr>
<tr>
<td>0</td>
<td>14</td>
<td>4.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>305</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Of all the women accepted to obtain abortions, 5.1% had had a previous abortion. A breakdown of this data is found in Table 21.

As Table 21 denotes, 2 (16.7%) women who had had one previous therapeutic abortion had never used a method of contraception. Although this fact only related to two women, it would seem that these patients could possibly be using abortion as a form of birth control. Although 14 (87.5%) women having previous therapeutic abortions had
used a contraceptive in the past, only 7 (43.7%) were practicing contraception at the time of conception. Evidently these methods were unreliable or improperly used because unwanted conception occurred.

**TABLE 21. --Previous Therapeutic Abortion(s) and Contraception Use Illustrated by Frequency**

<table>
<thead>
<tr>
<th>Contraception</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior to Conception:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Some</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td><strong>At Conception:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Some</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td><strong>Future Plans:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Some</td>
<td>12</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
</tbody>
</table>
In order to fully investigate this research question variables such as age, marital status, marital problems and contraceptive use could be co-related with repeaters. However, the investigation is limited because of the small number of repeaters. That analysis of the data is suggested as a subject for future research.

C. Question 4: Abortion Expected and Abortion Actually Performed

A woman's preparation for and knowledge of the abortion to be performed is important both for the patient's mental as well as physical health. i.e. In regard to a hysterotomy, patient preparation is necessary as there is a direct effect upon the length of the recovery period and also upon future child bearing. If there is a serious degree of infection, it is also possible for sterility to occur. The fourth research question asked:

Was there a significant relationship between the type of abortion the woman was told she would have and the abortion procedure actually performed?

Table 22 indicated that 164 (79.1%) women received the abortion procedure as explained to them by their physician. On the other hand, 32 (20.9%) patients were unprepared for their particular abortion procedure.

It may be assumed that the physician knew which abortion procedure he was referring to whenever the patient was told that she would be undergoing an "operation"
or obtaining an "abortion." However, as illustrated in Table 22, it would seem that this explanation was not always made clear to the patient.

**TABLE 22.** --- Abortion Procedure that the Patient Was Prepared For and the Actual Procedure Performed Illustrated by Frequency

<table>
<thead>
<tr>
<th>Procedure Prepared to Obtain</th>
<th>Procedure Actually Performed</th>
<th>D&amp;C and Vacuum</th>
<th>Induction</th>
<th>Hysterotomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>D&amp;C and Vacuum</td>
<td>145</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Abortion</td>
<td>21</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Operation</td>
<td>2</td>
<td>0</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Induction</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hysterotomy</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>160</td>
<td>18</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

Missing observations = 95

$\chi^2 = 284.50$  \hspace{1cm} df = 8  \hspace{1cm} P < .05

Cramer's $V = .81$

For example: Three women having a hysterotomy had not been told that they would be having an hysterotomy or an operation; 25 patients obtaining an abortion by D&C and Vacuum were told that they would either have an abortion, operation or induction; and, 8 women having an urea
induction had been told that they would be having an abortion or a D&C and Vacuum. Thus the women obtaining an abortion by a procedure other than that one for which they had been originally prepared, would not be aware of the physical risks or the after-care involved in regaining their good health.

C. Question 5: Pre and Post-Operative Information Received by Abortion Patients

The fourth question dealt with concern directed toward the concepts in regard to physical and mental preparation for the abortion procedure. The fifth research question asked:

Had the women received pre-operative and post-operative information in regard to their abortion procedure and their physical health?

In the interest of social work intervention, it might be noted that although only 1.6% (4) of the women stated that they had not received pre or post-operative information in regard to their particular abortion procedure, 53.7% (167) of the patients still asked the social worker for additional abortion information.

C. Question 6: Woman's Age and When Medical Advice Was First Sought

It would seem that the time when a woman first sought medical advice in regard to her pregnancy would have a direct bearing upon her physical health. There was
question whether the younger woman, due to immaturity, guilt, shame or fear, might delay in seeking the necessary medical guidance. Therefore, the sixth research question asked:

Was there a significant relationship between the woman's age and when she first sought medical advice?

The answer to this research question is found in Table 23.

**TABLE 23. — Patients' Ages and When Medical Advice Was First Sought (in Terms of Gestation Weeks) Illustrated by Percentage**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>5-6 wks.</th>
<th>7-12 wks.</th>
<th>13-18 wks.</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 - 48</td>
<td>47.4%</td>
<td>47.4%</td>
<td>4.9%</td>
<td>99.7% (n=19)</td>
</tr>
<tr>
<td>35 - 39</td>
<td>43.4</td>
<td>56.5</td>
<td>0.0</td>
<td>99.9 (n=23)</td>
</tr>
<tr>
<td>30 - 34</td>
<td>35.7</td>
<td>60.7</td>
<td>3.6</td>
<td>100.0 (n=28)</td>
</tr>
<tr>
<td>25 - 29</td>
<td>37.9</td>
<td>56.9</td>
<td>5.2</td>
<td>100.0 (n=58)</td>
</tr>
<tr>
<td>20 - 24</td>
<td>34.7</td>
<td>59.6</td>
<td>5.7</td>
<td>100.0 (n=72)</td>
</tr>
<tr>
<td>14 - 19</td>
<td>34.2</td>
<td>57.6</td>
<td>8.2</td>
<td>100.0 (n=111)</td>
</tr>
</tbody>
</table>

Missing observations = 0

\[ r = .0397 \quad t = -.6978 \quad P \ ns \]

A total of 36.7% (114) of the women obtaining abortions sought medical advice in the first six weeks of gestation. A large percentage of women, 57.1% (178),
sought medical advice between 7 and 12 weeks of gestation. As can be seen in Table 23, there was only a difference of 13.2% among the various age ranges with the greatest difference occurring after 35 years of age. A Pearson's r equal to .0397 and a "t" test of -.6978 demonstrated that there was no statistically significant relationship between the woman's age and when medical advice was sought. It should be noted that the age group where there was the highest incidence of waiting, until 13 to 18 weeks, was the teenage range, 14 - 19 years.

**Summary for Section C.**

As stated in the introduction to Section C, the concern in regard to secondary prevention grew out of the assumption that the risk to the patient's health would be less if: a) acceptable alternatives to the abortion could be found and b) that the surgical risk is reduced if the abortion is performed as early as possible.

A review of the literature indicated that there are definite possibilities for physical risks or side effects from any of the forms of abortion procedures. One might wonder if a woman could avoid the abortion and yet not have the responsibilities of child care. Approximately two-thirds of the patients stated that their physician offered them alternatives to abortion. The most frequent suggestion
was that of carrying the pregnancy to term and then placing the baby for adoption.

It is in a pregnant woman's best physical interests to see a physician as early in the pregnancy as possible. It was thought that there might be a significant relationship between a woman's age and when she first sought medical advice. There was no significant relationship. However, the teen age range contained the highest frequency of waiting from 13 to 18 weeks of gestation before seeing a physician. This extended wait would put a woman into her second trimester of pregnancy when abortion by D & C and Vacuum could no longer be performed. Hence a more involved procedure, with possible more serious risks, would have to be performed.

There were a small number of women accepted to obtain abortions who had had a previous abortion. It might be thought that a woman would take precautions to avoid the possibility of another abortion and its physical risks. However, there was no significant relationship between the woman's use of a contraceptive and whether or not she had had a previous therapeutic abortion or abortions. All the women stated that they would practice contraception after obtaining their abortion. Thus, women who had had previous abortions might then require further family planning education and counseling. The type of contraceptive used, further identification of the repeaters and
a follow-up study are possible areas for further research.

There was a significant relationship with a high strength of association between the type of abortion the woman was told she would have and the abortion procedure actually obtained. This relationship is satisfactory for the women to whom this fact applies. There were abortion patients who obtained their abortion by a procedure other than what they were originally told they would receive. It is this group of women who might require additional support or counseling as they would probably be unprepared for the procedure and its possible risks or after effects.

As stated in Chapter I, in relation to definitions of the three abortion procedures, the length of gestation has a great influence upon which form of abortion will be performed. The analysis of the data suggested that there were several women whose waiting period could have been directly responsible for an abortion procedure to be performed, other than the one originally possible at the time of the first medical contact. The women's doubts, fears or hesitancy to quickly follow the application process or tardy referral letters, difficulty in obtaining medical appointments, etc., could have been explanations for the delay.

In conclusion, there are several observations to be made from the data analysis in regard to avoiding the
abortion procedure or to obtaining the abortion as early in the pregnancy as possible and thus, reducing possible physical risks. Those observations were: alternatives to abortion as presented by the physician, were rejected by the patient in favor of the abortion; many women from all age ranges sought medical advice during the first six weeks of pregnancy; the teens had the highest frequency of those women waiting 13 to 18 weeks before seeking medical advice; there were 9 women (out of 16) who had had previous abortions and were not practicing contraception at the time of conception; and, there were patients who were not counseled in regard to the type of abortion they actually received. Thus, in the interest of secondary prevention counseling with the goal of reducing possible physical risks, the following aspects should be considered: offering appropriate and sufficient counseling and support in regard to abortion alternatives to women seeking abortions; making counseling easily available to women with actual or suspected problem pregnancies, especially teenager; one of the goals would be to help the women seek medical advice as early as possible; and, appropriately inform them of the three possible forms of abortions and of the related risks to their physical health.

Sections A, B and C have offered conclusions and implications that will hopefully help interested professionals
to gain a better understanding or clearer picture of who the women are that have been accepted to obtain abortions. The data thus far presented has described characteristics of abortion patients pertaining to a general description and in the interests of primary and secondary prevention. The final section, D, of this chapter will offer the data analysis and conclusions pertaining to tertiary prevention.

Section D: Data Pertaining to the Area of Tertiary Prevention

A review of the literature indicated that the majority of women do not suffer long term psychological disturbances as a result of an abortion. However, possible guilt feelings and other anxieties may develop immediately after an abortion and continue for several weeks. For these reasons, abortion counseling can be a positive intervention for the abortion patient. To discover what degree of counseling might be necessary, several areas could be examined; i.e. the woman's relationship with her family and with the father of the conceptus; whether or not the woman has any existing emotional problems; and, whether or not the woman needed reassurance in regard to her abortion decision. The emphasis of the research in the area of tertiary prevention
is to determine the presence or absence of relationships and other factors that would aid in reducing emotional trauma or other stress arising from the experience of obtaining an abortion.

Section D. Question 1: Parental Knowledge of Daughter's Abortion Plans

It is thought that if a woman is able to share her problems and concerns with those with whom she lives, she will probably experience a reduction in stress and anxiety. Therefore, the first research question asked:

If the woman was living with her parents, had she told them of her abortion plans?

There were 114 (36.7%) women accepted to obtain abortions who lived with a parent(s) and 100 (33.1%) for whom there was parental knowledge of the abortion. As can be seen by looking at Table 24, parental knowledge was largely dependent upon the woman's residence. There was no parental knowledge of the abortion for 58.6% (142) of the women. The reader is cautioned that this table includes married women who might feel that it was not necessary to inform their parents of the abortion plans.

D. Question 2: The Father of the Conceptus and His Knowledge of the Pregnancy

To continue the thinking in regard to emotional support for the patient, the second research question asked:
Was there a significant relationship between the father of the conceptus and whether or not he had knowledge of the pregnancy?

**TABLE 24. --Parental Knowledge of the Abortion Plans Cross Tabulated by the Woman's Residence Illustrated by Frequency and Percentage**

<table>
<thead>
<tr>
<th>Parental Knowledge</th>
<th>Residence</th>
<th>Parents</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>62.7% (64)</td>
<td>25.7% (36)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>37.3% (38)</td>
<td>74.3% (104)</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100.0% (102)</td>
<td>100.0% (140)</td>
<td></td>
</tr>
</tbody>
</table>

Missing observations = 59

$\chi^2 = 33.37$  $df = 1$  $P < .001$  $\phi = .37$.

Table 25 illustrates the data for this relationship. There was a definite relationship between who the father of the conceptus was and whether or not he knew of the pregnancy. The strength of association was moderate with a Cramer's V score of .52. It would appear that the more permanent the relationship, assuming marriage to be the most permanent, the more likely that the father of the conceptus had knowledge of the pregnancy.

While analyzing the data that pertained to research question 2, another question was asked:
Was there a significant relationship between whether or not the father of the conceptus had knowledge of the pregnancy and what would the involvement be with the woman after her abortion?

TABLE 25. --Father of the Conceptus and His Knowledge of the Pregnancy Illustrated by Percentage

<table>
<thead>
<tr>
<th>Father of Conceptus</th>
<th>Knowledge of Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Boyfriend</td>
<td>82.7%</td>
</tr>
<tr>
<td>Husband</td>
<td>95.0</td>
</tr>
<tr>
<td>Casual</td>
<td>29.2</td>
</tr>
<tr>
<td>Other</td>
<td>42.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>81.5%</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 70.89 \quad df = 3 \quad P < .001 \quad \text{Cramer's } V = .52 \]

As can be seen in Table 26, again, as with Question 2 of this section, there is a definite relationship between who the father of the conceptus is and what his future relationship will be with the woman after she has obtained her abortion. The findings would again indicate that the more permanent the relationship, the more likely
that the father of the conceptus had knowledge of the pregnancy. The strength of association was moderate with a Cramer's V score of .42.

TABLE 26. --Father of Conceptus and His Relationship With the Patient After Her Abortion Illustrated by Percentage

<table>
<thead>
<tr>
<th>Father of Conceptus</th>
<th>Relationship After the Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Continue As Is</td>
</tr>
<tr>
<td>Boyfriend</td>
<td>61.8%</td>
</tr>
<tr>
<td>Husband</td>
<td>92.1%</td>
</tr>
<tr>
<td>Casual</td>
<td>15.4%</td>
</tr>
<tr>
<td>Other</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

Missing observations = 54

\[ -\chi^2 = 90.71 \quad \text{df} = 6 \quad P < .001 \quad \text{Cramer's } V = .42 \]

D. Question 3: The Patient's Need for Reassurance and Whether or Not She Was Seen by the Social Worker

As the social worker provided the abortion counseling for the hospital and in terms of meeting the patients' needs, the third research question asked:

Did the patient need reassurance in regard to her abortion plans and if so, was she seen by the social worker?

As was previously stated in Section I of this
chapter, the social worker saw 187 (60.1%) patients. Of all the abortion patients, 65 (34.9%) specifically indicated a desire for reassurance. The answer to this third research question proved to be somewhat invalid as it was generally not known if the patient required reassurance unless the social worker could detect this desire through an interview. Nevertheless, as Table 27 indicates, 65 women requested help and the social worker was able to see 62 of them.

TABLE 27. --Patients' Expressed Need for Reassurance and Their Contact with the Social Worker Illustrated by Frequency

<table>
<thead>
<tr>
<th>Social Work Contact</th>
<th>Expressed Need for Reassurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>62</td>
<td>118</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>65</td>
<td>121</td>
</tr>
</tbody>
</table>

Missing observations = 125

Table 27 states that of 186 women almost one-third expressed a need for reassurance regarding their decision to obtain an abortion. This fact is an indication of the stress and anxiety an abortion patient may be experiencing
and they present an excellent opportunity for tertiary prevention through social work intervention.

D. Question 4: The Woman's Age and the Support Received From the Father of the Conceptus

Because many of the women being accepted to obtain abortions seemed to be young, there was query in regard to the emotional support that they might be receiving. Thus the fourth question asked:

Was there a significant relationship between the woman's age and the support received from the father of the conceptus?

Table 28 indicates that as the age range increased in years, the amount of help, with making the abortion decision, from the father of the conceptus rose as well. The score for Cramer's V was .36 indicating a low strength of association.

To add an extra dimension to this discussion, it was decided to also look at whether or not the patient was requesting some additional reassurance as well as looking at the identity of the father of the conceptus.

The basis for Table 29 was the 65 women who requested reassurance. Table 29 indicated that the most reassurance was required from those women 14 - 19 years of age and for whom their boyfriend was the father of the conceptus. The data supports evidence of a significant relationship with a Cramer's V equalling .53 indicating a moderate strength of association.
TABLE 28. --Age and Patient Support Received from the Father of the Conceptus in Regard to the Abortion Decision Illustrated by Percentage

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Yes</th>
<th>No</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 - 48</td>
<td>88.2%</td>
<td>11.8%</td>
<td>100.0% (n=17)</td>
</tr>
<tr>
<td>35 - 39</td>
<td>85.7</td>
<td>14.3</td>
<td>100.0 (n=21)</td>
</tr>
<tr>
<td>30 - 34</td>
<td>84.6</td>
<td>15.4</td>
<td>100.0 (n=26)</td>
</tr>
<tr>
<td>25 - 29</td>
<td>66.7</td>
<td>33.3</td>
<td>100.0 (n=54)</td>
</tr>
<tr>
<td>20 - 24</td>
<td>46.3</td>
<td>53.7</td>
<td>100.0 (n=54)</td>
</tr>
<tr>
<td>14 - 19</td>
<td>43.2</td>
<td>56.8</td>
<td>100.0 (n=88)</td>
</tr>
</tbody>
</table>

Missing observations = 51

$\chi^2 = 33.32$  \( df = 5 \)  \( P < 0.001 \)

Cramer's $\text{V} = .36$

Summary for Section D

It appears that there is a valid reason to be concerned about tertiary prevention in regard to abortion patients. Recent studies have shown that there are usually no long lasting psychological problems resulting from a woman obtaining an abortion. The studies do suggest that there are immediate "short term" problems resulting perhaps from feelings of guilt or stress and anxiety.

Parental knowledge of their daughter's abortion
plans was largely dependent upon the woman's residence. There was no parental knowledge of the abortion for 37.3% of the patients living with their parents. This situation would probably create stress for the women who were living at home and trying to keep their pregnancy and abortion plans secret.

TABLE 29. ---Abortion Patients Who Requested Reassurance Cross Tabulated by Age and the Father of the Conceptus Illustrated by Percentage

<table>
<thead>
<tr>
<th>Father of the Conceptus</th>
<th>Age Range</th>
<th>Husband</th>
<th>Boyfriend</th>
<th>Casual</th>
<th>Don't Know</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40 - 48</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0% (n=5)</td>
</tr>
<tr>
<td></td>
<td>35 - 39</td>
<td>100.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0 (n=4)</td>
</tr>
<tr>
<td></td>
<td>30 - 34</td>
<td>100.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0 (n=5)</td>
</tr>
<tr>
<td></td>
<td>25 - 29</td>
<td>53.3</td>
<td>20.0</td>
<td>26.7</td>
<td>0.0</td>
<td>100.0 (n=15)</td>
</tr>
<tr>
<td></td>
<td>20 - 24</td>
<td>20.0</td>
<td>70.0</td>
<td>0.0</td>
<td>10.0</td>
<td>100.0 (n=10)</td>
</tr>
<tr>
<td></td>
<td>14 - 19</td>
<td>3.8</td>
<td>88.5</td>
<td>7.7</td>
<td>0.0</td>
<td>100.0 (n=26)</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>38.5%</td>
<td>50.8%</td>
<td>9.2%</td>
<td>1.5%</td>
<td>100.0% (n=65)</td>
</tr>
</tbody>
</table>

\[-12^2 = 54.26 \quad df = 15 \quad P < .001\]

Cramer's $V = .53$

It is assumed that there would be emotional ties of some kind between the abortion patient and the father
of the conceptus. The data analysis pointed out that the more permanent the relationship between the patient and the father of the conceptus, the more likely he knew of the pregnancy and abortion plans, and the more likely that the relationship would continue through, and after, the abortion process. It was also found that the younger the woman, the less support she received from the father of the conceptus.

Another phase of the data analysis, in regard to the abortion patients' emotional health, was contact with the social worker. There were 65 patients who expressed a desire for reassurance in regard to their abortion plans. The social worker saw 62 of those women. Because the social worker did not see all 311 abortion patients and hence, unable to determine if there was a need for reassurance or additional emotional support, there might have been women whose needs were not met. Consequently a follow-up counseling program could prove to be beneficial for the patients after obtaining their abortions.

In the interest of alleviating or decreasing the opportunities for emotional problems to develop as the result of an abortion, all women who are seeking abortions should receive problem pregnancy counseling. According to the analysis of the data, it is suggested that there
be an emphasis on counseling women with any of the following characteristics: teen aged, single marital status, no one has knowledge of her pregnancy and abortion plans, has not received any supportive help from the father of the conceptus, and, has requested reassurance about her decision to obtain an abortion.

Summary for Chapter III

The data analysis provided answers to the research questions in the following areas: primary prevention, secondary prevention and tertiary prevention. The research questions were not meant, by any means, to be all inclusive in each of the three areas of prevention. In addition to a general description of women who have been accepted to obtain abortions in a general hospital, meaningful relationships were discovered between some of the variables. Hopefully the general descriptions and conclusions will be of value to medical and counseling personnel in terms of offering effective treatment and counseling to women with problem pregnancies who are considering obtaining an abortion.

Now that the data has been analyzed, Chapter IV will tie together Chapters I through III and also present limitations of the study as well as suggestions for future research.
CHAPTER IV

SUMMARY AND CONCLUSION

The purpose of this research project was to describe a population which was, women who were accepted to obtain abortions in a general hospital. The emphasis for this study included four areas: a general population description; primary prevention; secondary prevention; and, tertiary prevention.

Through the study it was the intention to describe the abortion patients with variables such as age, marital status, religious affiliation, contraceptive practice, education and family relationships. Additionally, there was a search for variable relationships between several variables within the perimeters of this study.

The study began when the Abortion Committee of a general hospital felt that the teenagers and women requesting abortions might have some problems in regard to the patient coping with an abortion. An assumption that the social worker as researcher held was that the patient required counseling and family planning advice because the abortion itself was not the real issue with the patient; rather, that the pregnancy was unwanted and as a result, the abortion was being requested.
The social worker at the researched hospital sought to discover some characteristics and facts about this group of women in order to enable the health care team to maximize their effectiveness when dealing with abortion patients. It was due to the Abortion Committee's request for some statistical type of information about the patients who were accepted for abortions; and, due to the author's desire to offer effective counseling that this study was initiated. It was also hoped that through the findings of the study, a future program could be developed, or an existing service broadened to meet the needs of this population of women. The project was not designed to test explicit hypotheses, but rather to describe a population and to answer research questions.

Research Design

The coded response sheet was used to record information as to certain selected characteristics of the sample. There were 65 independent variables described. These independent variables were related to the four areas of the study: a general population description; primary prevention; secondary prevention; and, tertiary prevention. The computer was used to analyze the data.

Chi-square was the statistic most often used to determine whether or not there were significant relationships
and the level of significance used was .05. Cramér's V, phi and r were used to test the strength of the relationship.

**Characteristics of the Sample**

There were 311 women who were accepted to obtain abortions at a Windsor general hospital from December 1973 through June 1975. The researcher was able to obtain data in regard to all the patients although only 58.5% were personally interviewed. The sample was made up of women ranging in age from 14 through 48 years. The largest group was the teens (14 – 19) which accounted for 35.7% of the sample with the mode being seventeen year olds. It appeared that 75.5% of the women were from the city of Windsor and that approximately 37% still lived in their parental home.

The sample was further described by the marital status. Married women made up 30.5% of the sample, 55.9% were single and 13.6% were separated, divorced or widowed. Religious affiliation was another facet of the sample. The Roman Catholics constituted 42.4% of the sample. Quite unexpectedly, it was found that 36.3% of the sample had never practiced contraception and 67.9% were not using a contraceptive when conception occurred. It should also be added that the largest number of abortions (254) were obtained by a D & C and Vacuum, with 21 hysterotomies and
36 urea inductions also being performed. The waiting period varied from one to eight weeks, with 50% of the women only having to wait two weeks from the time of seeing the first referring physician until the abortion was actually performed.

**Research Questions**

In this research project there was a search for relationships among the independent variables. The research questions were appropriately grouped under one of the three main areas of the study. Cross tabulations and subsequent statistical analysis provided the means of investigating the research questions.

The first set of research questions were related to the area of primary prevention. The variable contraception was cross tabulated with religious affiliation, age, marital status, sexual activity and education in order to discover if there were significant relationships.

As was reflected in Section B of Chapter III, contraceptive use prior to conception, at conception and future plans for contraception were significantly related, in varying degrees, to religious affiliation, age, sexual activity and marital status. Another determinate in regard to contraceptive use was the woman's completed level of education. It was felt that education
was not the main factor in the relationship as with women under the age of 17 or 18, there would have been an underlying relationship with age.

Of all the religious affiliations, women belonging to the Roman Catholic faith were the least likely to have made use of contraception prior to conception. There was no significant relationship between religious affiliation and contraception at the time of conception or with contraceptive plans for the future. All the women, except 9.2% had either undergone a sterilization procedure after the abortion or else planned to practice birth control.

Age played an important factor with the practice of contraception. It was the younger aged (14 through 19 years) women who were the least likely to have practiced contraception prior to conception. It was also the teens, although a small number, who were the least likely to practice some form of contraception after obtaining their abortions. Several women in this teen group stated that they felt that contraception was not "natural" or that they would not be engaging in intercourse again until they were older.

Marital status was also a major determinant to be considered in regard to the practice of contraception.
Approximately 90% of all the married women had practiced contraception but only 50% of the single women had done so. At the time of conception, 53.6% of the married women but only 23.1% of the single women were using a contraceptive. All the married women and all but 14.8% of the single women planned to practice some form of birth control in the future.

The final variable handled under the heading of primary prevention was sexual activity. The data pointed out that the longer the period of time in which sexual activity occurred, the more likely that the woman had practiced contraception. Several young, teenaged girls had expressed to the social worker that they believed women could not get pregnant the first time that they engaged in sexual intercourse or if the sexual act was not completed. Their family planning information would appear to be inadequate. It was mainly the younger group of women who had engaged in sexual intercourse over a five month or less period of time. Almost three-fourths of this group of women had never practiced contraception.

In the interest of family planning, the women who would be prime targets to receive family planning counseling are the ones who would most likely be seeking abortions. The following characteristics describe that population of women: teenaged; attending school in grades 8 through 12; single; have been sexually active for a short period of
time; and, belong to the Protestant faith more than any other denomination.

The description of women accepted to receive abortions was further investigated through research questions that pertained to the woman's physical health after obtaining an abortion. This group of research questions came under the heading of secondary prevention. The concern in regard to the abortion patient's physical health was considered for the study because a review of the literature indicated that there are definite physical risks or side effects of abortion. The assumption was that the risk to the woman's health would be less if the abortion could be avoided or if not, then that the abortion be performed as early in the pregnancy as possible.

For physical health reasons, it is important that a pregnant woman seek medical advice as early as possible. Most women saw their physician within the first six weeks of gestation; soon after suspecting or discovering the presence of a pregnancy. Some women waited, however, until 13 to 18 weeks of gestation. It was the 14 through 19 year olds that had the highest incidence of being in the second trimester of pregnancy before seeking medical guidance. Otherwise, there was no significant relationship between age and seeking medical advice.

There were not many women who were seeking a
repeated abortion. These women did not differ from the rest of the abortion patients in regard to contraceptive use at the time of conception. Because there were such a low number of repeaters during this study, it was not possible to further describe these women accurately.

Many women (79.1%) received the abortion procedure as explained by their physician. It is important to note that the remaining abortion patients had not been adequately prepared to expect or understand the dynamics, i.e. hospitalization, possible risks, and side effects, of the abortion procedure that was performed. The data also indicated that the length of gestation had a direct affect on which form of abortion would be carried out. Therefore, a lengthy waiting period could necessitate a change in the abortion procedure. This situation would constitute the opportunity for secondary prevention and social work intervention as defined in Chapter I.

The fact that the patients (65.2%) were offered alternatives to abortion should not be overlooked. The most frequent suggestion was for the woman to carry the pregnancy to term and then place the baby for adoption. Thus the abortion could have been avoided as well as the responsibilities involved in caring for a baby. It is evident that the suggestions were not acceptable to the women as they went ahead with their plans for an abortion.
The third group of research questions dealt with tertiary prevention. This area of the study was examined with an emphasis on alleviating possible short-term psychological problems that a woman might develop as the result of obtaining an abortion. Variables concerning the abortion patient's relationship with her family, friends and the father of the conceptus were cross tabulated with their knowledge and approval of the abortion plans to determine whether or not the patient was obtaining support from them. This assumed support might help to alleviate possible mental health problems.

Parental knowledge of their daughter's plans for abortion was largely dependent upon the daughter's residence. The reader is reminded that all the women in the sample were included in this calculation. Therefore, a mature woman might be living at home but have no need nor no desire to discuss her abortion plans with her parents. There were 75% of the patients living with parental families for whom there was parental knowledge of the abortion plans. The remainder of the women living with their parents were attempting to keep the pregnancy and abortion a secret. Many of the patients stated that they felt their parents would become too upset if they were to know of the impending abortion.

The support of the father of the conceptus was
also considered as a variable that would influence the abortion patient's state of mental health. There were some women who did not want to see or have anything to do with the father of the conceptus. The statistics did indicate that the more permanent the relationship seemed to be, the more likely that the father of the conceptus provided the abortion patient with emotional support. Age also had a direct bearing on the emotional support received from the father of the conceptus. The analysis of the data suggested that the younger the woman, the less support she received from the father.

Lastly, the intervention by the social worker was examined. The social worker was able to counsel all but two of the women who requested additional reassurance from the social worker. The remainder of the women, again except for two, were willing to see the social worker and when made free to do so, expressed many of their problems, anxieties or concerns.

The preceding paragraphs have presented a summary of the findings of this project dealing with abortion patients in a general hospital. The next segment of this chapter will deal with the conclusions drawn from the analysis of the data.
Conclusions

The conclusions of this study will be presented in the following two segments: conclusions identifying the abortion patients and, conclusions incorporated into a guideline for abortion counseling.

It was found from the results of this project that a generalized statement in regard to the accepted abortion patient was that she was likely to be under 20 years of age; single, live with her parents; belong to the Roman Catholic faith; be in grade 12 or under; have never practiced contraception; had requested pre and post abortion information; was seen by the social worker; and, obtained the abortion by D & C and Vacuum.

Effective family planning would mean that there would be no need for an abortion and hence no resulting physical or mental effects as the result of obtaining the abortion. The research results seem to highlight contraception as related to several independent variables such as age, religion, marital status, education and sexual activity. One-third of the abortion patients had never practiced contraception. At the time of conception, only 30% were attempting to use some form of birth control. Counseling with the abortion patients revealed that there were some erroneous concepts about birth control methods and that accurate birth control information regarding the
use of contraceptives and aspects of sexual behavior was required.

In regard to the contraceptive practice after obtaining the abortion, all but 8.8% of the women were going to undergo a sterilization procedure or practice a reliable form of contraception. It would appear that the women not desiring to practice birth control would be prime candidates for follow-up counseling, especially if they did not want a pregnancy and yet were engaging in unprotected intercourse. Those women stating that they would be practicing contraception could possibly benefit from supportive counseling reinforcing accurate family planning instructions.

The Roman Catholic Church takes a definite position against contraception (except the rhythm method) and is definitely against abortion. Regardless of this fact, the Roman Catholic women represented the largest religious denomination group seeking abortions, although there were more non-Catholics than Catholics in the sample. It is hypothesized that this group of women might need some help and support in making their abortion decision and also in coping with possible psychological after-effects.

The majority of women who were considered sexually active knew about contraceptives although they may not have been trying to utilize this knowledge at the time.
conception took place. Most of those women having their initial intercourse experience or those who only had intercourse occasionally had never practiced contraception. If unwanted pregnancies are to be prevented, the less sexually active or inexperienced women would need to be provided with family planning information and guidance.

Education had a direct relationship with the practice of contraception. The higher the level of education, the more likely that the patient would have practiced some form of contraception. In the interest of family planning, it should be noted that those students in grades 12 and under have a higher incidence of non-contraceptive use and perhaps this fact suggests that there needs to be more comprehensive family planning education for these grade levels.

Approval to obtain an abortion was received by more single women than the total of married and previously married women. Most of the married and previously married women had practiced contraception prior to conception. However, this statement held true for less than one-half of the single women. Because many single women had not used a contraceptive, it is thought that perhaps due to their "single" status, they might have been embarrassed or reluctant to seek medical advice in this regard or to actually make a contraceptive purchase. Also, a contraceptive
might not have been used because the episode of intercourse had occurred unexpectedly.

The age of the abortion patient was an important factor in several of the variable relationships. The teenager had the greatest concentration of unprotected intercourse. The highest frequency for no contraceptive use in the future was also found in this teen group. It is thought that the teens who do not practice or plan to practice contraception will be candidates for repeat problem pregnancies and subsequent abortions unless they receive emotional support and realistic, thorough physical and sexual advice.

Although the majority of patients sought medical advice early in their pregnancy, the teens constituted the greatest frequency of women going into their second trimester of pregnancy before seeking medical advice. It was also the teenagers who were likely to receive the least amount of support from the father of the conceptus. Thus, the data analysis seems to conclude that the abortion patients 14 through 19 years of age have many needs that could be met through intervention by the medical health team.

A review of the literature has suggested that some of the women who have sought a therapeutic abortion seem to have experienced difficulties which have affected their
ability to cope with any stressful situation. The patients expressed some of their anxieties and problems to the social worker. Much of their concern seemed to be centered around the hospitalization and abortion procedures, and others were around their relationships with their families and with the father of the conceptus. It would then appear that most of the women facing the problem of an unwanted pregnancy could utilize crisis-orientated, short-term casework or guidance depending on the need of the individual. The crisis could prove to be a period of opportunity for changes to be made toward increased health and maturity.

Several conclusions drawn from the data analysis have pointed to areas that could be incorporated into crisis-orientated intervention such as, reassurance, the waiting period, parental knowledge of the abortion, and pre and post abortion information. Therefore, it is suggested that the effective counseling offered to abortion patients might include the following aspects:

1. Explaining the abortion and hospitalization procedures so that the patient will know what to expect;
2. Helping the woman to cope with what she feels are frustrations or negative aspects of the abortion process;
3. Offering the woman an opportunity to ventilate her anxieties and fears as well as clarifying her needs;

4. Providing or referring the woman to counseling, perhaps both family planning and psychosocial, that will hopefully meet the needs of the patient and also offset recidivism;

5. Assisting the woman in making alternative plans if the abortion request is denied;

6. Offering counseling to both partners in order to obtain the needed emotional support of the abortion patient and to meet the needs of the father of the conceptus as well;

7. Offering counseling, if applicable, to the abortion patient and her family;

8. Being open to accept the position of advocate on the patient's behalf.

As can be seen from the coded master sheet found in the appendix, data was gathered from a multitude of variables. The conclusions that have been discussed in this study are seen as the stepping stones for future research, perhaps with specific hypothesis to be tested. Before offering suggestion for further research, the limitations of this study will be discussed.
Limitations of the Study

There are several limitations of this study that the reader should note and take into consideration when considering the findings of this research project.

Inasmuch as the researcher was not able to personally interview all the sample, there were some missing observations. It is possible that some of the findings presented in the data would be influenced and changed if the data gathering had been more complete.

Although the sample contained a few women from outside the area of Essex County, by limiting the study to one hospital in one specific county of Ontario, the generalizations and findings may also be limited to the immediate area. The reader is also reminded that the information regarding religious affiliation may also be limited to Essex County, also Windsor, as they contain a large Roman Catholic Population.

The instrument used to record the patient responses was devised by the researcher based upon the type of information sought by the Abortion Committee at the researched hospital and upon the intention of the researcher to identify this group of women. There is the possibility, therefore, that the findings of the study may only apply to the researched hospital.

The reader is cautioned that much of the information
relating to what the physician might have told the patient was gathered from the patient herself rather than from the physician. Hence, there may be some distortion of the answers in those related areas.

Lastly, the reader is reminded that the researched hospital is a Protestant hospital that strongly identifies with traditions and a Christian dogma. Consequently, the sample gathered from this hospital may not be representative of abortion patients in other hospitals in Essex County.

Suggestions for Further Study

All the discussion in this study has centered around women who have received approval to obtain an abortion. It must be noted that during the time that the study was in progress, there were women whose applications for approval to obtain abortions were rejected. These women may indeed have felt rejected and discouraged. Research in the interest of discovering more about that group of women, and the problems unique to their situation would be most enlightening.

Another suggestion for future research would be to study the women who have had two or more therapeutic abortions. Further identification and a follow-up study could well fit into the preventive model. In terms of providing adequate abortion alternatives, further research
could be conducted to determine why alternative suggestions to abortion were not accepted by abortion patients.

The conclusions of this current research project, in regard to tertiary prevention, pointed to a need for follow-up counseling in terms of providing emotional support during the time of recuperation and to reinforce family planning concepts. A further study or extension to this project could assess the supportive counseling received by the patient during the abortion process and also determine if the birth control plans were being followed or discarded.

As has been previously mentioned in this chapter, a great deal of data was gathered but all of it was not investigated, i.e. employment; relationship with the family of the father of the conceptus; the amount of children the patient might have and their ages; the patients' type of housing; the length of the marriage; the incidence of previous spontaneous abortions; and, the basis upon which the abortion request was accepted. In addition to what has already been learned, more timely relationships might be discovered that would prove beneficial to the abortion patient and to the health care team. The preceding variables were not analyzed for purposes of this research project as they did not pertain directly to the research questions and because there was
an academic time limit.

In conclusion, the entire subject of abortion has been controversial for years and years. Nevertheless, women have continued to seek abortions in spite of the controversy and all the pros and cons. Therefore, it is hoped that this study and future studies will prove to be an asset in identifying this group of women and helping them to meet their needs through counseling and social work intervention.
APPENDIX

CODED RESPONSE SHEET

<table>
<thead>
<tr>
<th>COLUMN</th>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>1 &amp; 2 AGE</td>
<td></td>
</tr>
<tr>
<td>RESIDENCE AREA</td>
<td>R 1 Windsor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 2 Leamington</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 3 Essex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 4 Amherstburg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 5 Wheatly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 6 Kingsville</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 7 Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 8 LaSalle</td>
<td></td>
</tr>
<tr>
<td>MARITAL STATUS</td>
<td>R 1 Single</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 2 Married or c/l</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 3 Separated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 4 Divorced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 5 Widowed</td>
<td></td>
</tr>
<tr>
<td>RELIGIOUS AFFILIATION</td>
<td>R 1 R. C.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 2 United</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 3 Anglican</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 4 Lutheran</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 5 Baptist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 6 Other Prot.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 7 Hebrew</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 8 Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 9 No Answer</td>
<td></td>
</tr>
<tr>
<td>DOCTOR</td>
<td>R 1 Dr. J.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R 2 Dr. H.</td>
<td></td>
</tr>
</tbody>
</table>
ABORTION PROCEDURE

R 1 D & C and Vacuum
R 2 Urea Induction
R 3 Hysterotomy

REFERRAL TO SOCIAL WORKER

R 1 Prior to hospital
R 2 Hospital arrival
R 3 Post-operative
R 4 Post Hospital
R 5 Never Seen

ABORTION APPROVED BUT NOT PERFORMED

R 1 Not pregnant
R 2 Decided to have baby
R 3 Unhappy with hospital procedure
R 4 Unknown reason
R 5 Doesn't apply
R 6 Spont. abortion on own
R 7 Had abortion elsewhere
R 8 Uterus too large

GESTATION WEEKS WHEN DISCOVERED PREGNANCY

WHICH DOCTOR DID YOU FIRST SEE

R 1 Family doctor
R 2 General Practitioner
R 3 Specialist
R 4 ACCRA
R 5 Windsor Health Unit
R 6 Other
R 9 No answer

WHEN SEE FIRST CONSULTANT DR. (Gest. Wks.)
WHEN SEE SECOND CONSULTANT DR. (Gest. Wks.)
APPROVED DATE OF ABORTION (Terms of Gest. Wks.)
ABORTION PERFORMED (Terms of Gest. Wks.)
21 DR'S OFFICE TELL PT. TO CONTACT SOCIAL WORKER
   R 1 Yes
   R 2 No
   R 9 No answer

22 WHAT TYPE OF ABORTION WERE YOU TOLD YOU WOULD HAVE
   R 1 D & C and Vacuum
   R 2 Operation
   R 3 Induction
   R 4 Hysterotomy
   R 5 "Abortion"
   R 9 No answer

23 WERE YOU TOLD THE LENGTH OF HOSPITAL STAY
   R 1 Yes
   R 2 No
   R 9 No answer

24 WERE YOU GIVEN PRE-OPERATIVE INSTRUCTIONS
   R 1 Yes
   R 2 No
   R 9 No answer

25 WHAT ALTERNATIVES DID DOCTOR SUGGEST
   R 1 Have abortion
   R 2 Carry Preg. & place for adopt.
   R 3 Carry preg. & keep baby
   R 4 Carry preg. & place temp.
   R 5 Wouldn't give any advice
   R 9 No answer

26 HOW LONG HAD SEX RELATIONS
   R 1 1st. time
   R 2 2 - 4 exposures
   R 3 2 - 5 months
   R 4 6 - 12 months
   R 5 Over a year
   R 9 No answer
### WHY WANT ABORTION

<table>
<thead>
<tr>
<th>R 1</th>
<th>Too young</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 2</td>
<td>Low finances</td>
</tr>
<tr>
<td>R 3</td>
<td>No husband</td>
</tr>
<tr>
<td>R 4</td>
<td>Poor physical health</td>
</tr>
<tr>
<td>R 5</td>
<td>Interfere with school or work</td>
</tr>
<tr>
<td>R 6</td>
<td>Multiparity</td>
</tr>
<tr>
<td>R 7</td>
<td>Older woman</td>
</tr>
<tr>
<td>R 8</td>
<td>Vas. or Salp. failed</td>
</tr>
<tr>
<td>R 9</td>
<td>Interferred with life style</td>
</tr>
</tbody>
</table>

### FATHER OF CONCEPTUS

<table>
<thead>
<tr>
<th>R 1</th>
<th>Husband c/l</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 2</td>
<td>Boyfriend</td>
</tr>
<tr>
<td>R 3</td>
<td>Incest</td>
</tr>
<tr>
<td>R 4</td>
<td>Casual acquaintance</td>
</tr>
<tr>
<td>R 5</td>
<td>Reported rape</td>
</tr>
<tr>
<td>R 6</td>
<td>Unreported rape</td>
</tr>
<tr>
<td>R 7</td>
<td>Don't know</td>
</tr>
<tr>
<td>R 9</td>
<td>No answer</td>
</tr>
</tbody>
</table>

### HEALTH PROBLEMS

<table>
<thead>
<tr>
<th>R 1</th>
<th>Mental/emotional illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 2</td>
<td>Physical illness</td>
</tr>
<tr>
<td>R 3</td>
<td>Physical disability</td>
</tr>
<tr>
<td>R 4</td>
<td>No health problem</td>
</tr>
<tr>
<td>R 5</td>
<td>Drug addiction</td>
</tr>
<tr>
<td>R 9</td>
<td>No answer</td>
</tr>
</tbody>
</table>

### CRITERIA FOR APPROVAL FOR ABORTION

<table>
<thead>
<tr>
<th>R 1</th>
<th>Immaturity</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 2</td>
<td>Mental health</td>
</tr>
<tr>
<td>R 3</td>
<td>Age</td>
</tr>
<tr>
<td>R 4</td>
<td>Physical health</td>
</tr>
<tr>
<td>R 5</td>
<td>Family size</td>
</tr>
<tr>
<td>R 6</td>
<td>Rape</td>
</tr>
<tr>
<td>R 7</td>
<td>Incest</td>
</tr>
<tr>
<td>R 8</td>
<td>Other</td>
</tr>
</tbody>
</table>

### LENGTH OF MARRIAGE

<table>
<thead>
<tr>
<th>R 1</th>
<th>Under 6 mos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 2</td>
<td>6 mos. - 1 year</td>
</tr>
<tr>
<td>R 3</td>
<td>2 - 5 years</td>
</tr>
</tbody>
</table>
32 DOES HUSBAND KNOW OF PREGNANCY
R 1 Yes
R 2 No
R 3 Doesn't apply
R 9 No answer

33 DOES HE OR FATHER OF CONCEPTUS APPROVE OF ABORTION
R 1 Doesn't know about it
R 2 Approves
R 3 Disapproves
R 9 No answer

34 IS YOUR FAMILY AWARE OF PREGNANCY
R 1 No one
R 2 Mother only
R 3 Father only
R 4 Both parents
R 5 Grandparents
R 6 Guardians
R 7 A sibling
R 8 Whole family
R 9 No answer

35 DO THEY APPROVE OF ABORTION
R 1 Doesn't know about it
R 2 Approves
R 3 Disapproves
R 9 No answer

36 IS FATHER OF CONCEPTUS'S FAMILY AWARE OF PREGNANCY
R 1 No one
R 2 Mother only
R 3 Father only
R 4 Both parents
R 5 Grandparents
R 6 Guardian
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R 7 Sibling
R 8 Whole family
R 9 No answer

37 DO THEY APPROVE OF ABORTION

R 1 Doesn't know
R 2 Yes
R 3 No
R 9 No answer

38 HOW LONG KNOWN FATHER OF CONCEPTUS

R 1 Less than 1 mo.
R 2 2 - 6 mos.
R 3 7 - 12 mos.
R 4 2 years
R 5 3 years
R 6 Over 4 years
R 7 Doesn't apply
R 9 No answer

39 DOES HE KNOW OF PREGNANCY

R 1 Yes
R 2 No
R 9 No answer

40 RESIDENCE

R 1 Room
R 2 Own apartment/town house
R 3 Share apartment/town house
R 4 Own house
R 5 Share house
R 6 Transient
R 7 With parents
R 8 Others
R 9 No answer

41 KIND OF SUPPORT FATHER OF CONCEPTUS GIVING YOU

R 1 Helped make decision
R 2 Left decision up to me
R 3 Deserted
R 4 Financial only
R 5 No help
R 9 No answer
WHO DO YOU LIVE WITH

R 1 Husband c/l
R 2 Boyfriend
R 3 Girlfriend
R 4 Relative
R 5 Alone
R 6 Group of people
R 7 Parents
R 8 With children
R 9 No answer

ININVOLVEMENT WITH FATHER OF CONCEPTUS AFTER ABORTION

R 1 Continue relationship as is
R 2 Will see but not date
R 3 Nothing to do with him
R 9 No answer

WHO ELSE KNOWS OF PLAN FOR ABORTION

R 1 Girlfriend
R 2 Minister
R 3 Counselor
R 4 Other close friends
R 5 No one
R 9 No answer

WERE SATISFIED WITH WAY SITUATION HANDLED BY DOCTOR

R 1 Yes
R 2 No
R 9 No answer

WERE SATISFIED WITH WAY SITUATION HANDLED BY NURSE OR SECRETARY

R 1 Yes
R 2 No
R 9 No answer

WHAT CONTRACEPTIVES HAVE YOU USED

R 1 None
R 2 Condom
R 3 Diaphragm
R 4 Rhythm
R 5 I.U.D.
WHAT FORM CONTRACEPTIVE USING AT TIME OF CONCEPTION

R 6 Pill
R 7 Foam
R 8 Other
R 9 No answer

WHAT FORM CONTRACEPTIVE WILL USE AFTER ABORTION

R 1 None
R 2 Maybe something if needed
R 3 Pill
R 4 Condom
R 5 Loop
R 6 Diaphragm
R 9 No answer

IF NO TO ABOVE WHY NOT

R 1 Doesn't apply
R 2 Vasectomy
R 3 Tubes tied
R 4 Hysterotomy
R 5 No involvement
R 6 Don't want to
R 9 No answer

WHO DISCUSSED CONTRACEPTION WITH YOU

R 1 Parent/s
R 2 School
R 3 Doctor
R 4 Self knowledge only
R 5 Counselor
R 6 Friend
R 9 No answer
52 HOW MANY CHILDREN DO YOU HAVE
(0, 1, 2, 3, 4, 5, 6, 7, 8, 9)

53 & 54 AGE OF ELDEST
(77) Placed for adoption
(88) Under 1 yr.
(99) No answer

55 & 56 AGE OF YOUNGEST
R 77 Placed for adoption
R 88 Under 1 yr.
R 99 No answer

57 HUSBAND'S OCCUPATION
R 1 Doesn't apply
R 2 Professional
R 3 White collar
R 4 Skilled Trade
R 5 Unskilled
R 6 Unemployed
R 7 Student
R 8 Disabled
R 9 No answer

58 BOYFRIEND'S OCCUPATION
R 1 Doesn't apply
R 2 Professional
R 3 White collar
R 4 Skilled Trade
R 5 Unskilled
R 6 Unemployed
R 7 Student
R 8 Disabled
R 9 No answer

59 FATHER'S OCCUPATION
R 1 Doesn't apply
R 2 Professional
R 3 White collar
R 4 Skilled Trade
R 5 Unskilled
R 6 Unemployed
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R 7 Student
R 8 Disabled
R 9 No answer

60 IF SEPARATED OR DIVORCED RECEIVED ANY FINANCIAL SUPPORT

R 1 Doesn't apply
R 2 No
R 3 Support for self only
R 4 Support for children only
R 5 Support for self and children
R 9 No answer

61 ANY MARITAL PROBLEMS

R 1 Doesn't apply
R 2 No
R 3 Husband in jail
R 4 Husband deserted
R 5 Physical abusement
R 6 Emotional abusement
R 7 Personality problem
R 8 Financial
R 9 No answer

62 & 63 HOW MANY YEARS SCHOOLING COMPLETED

(99) No answer

64 YOUR EMPLOYMENT

R 1 Not employed
R 2 Clerking
R 3 Factory work
R 4 Secretarial
R 5 Nurse
R 6 Teacher
R 7 Hair Dresser
R 8 Other
R 9 No answer

65 IF STILL IN SCHOOL -- WHAT SCHOOL

R 1 Doesn't apply
R 2 Under grade 13
R 3 Upgrading
R 4 Community College
R 5 University
R 6 Correspondence courses
R 7 Special training
R 8 Other
R 9 No answer

REASON FOR UNEMPLOYMENT
R 1 Doesn't apply
R 2 Housewife
R 3 Welfare
R 4 Unemployment insurance
R 5 Mother's allowance
R 6 Disability pension
R 7 Adult Ed. check
R 9 No answer

RESIDENCE MAJORITY OF LIFE
R 1 Essex County
R 2 Canada
R 3 South America
R 4 U.S.A.
R 5 United Kingdom
R 6 Far East
R 7 Mediterranean Area
R 8 Other
R 9 No answer

PATIENT REQUIRED INFO RE ABORTION PROCEDURE
R 1 Yes
R 2 No
R 9 No answer

PATIENT REQUIRED INFO RE AFTER CARE & ABORTION EFFECTS
R 1 Yes
R 2 No
R 9 No answer

PATIENT CO-OPERATIVE WITH SOCIAL WORKER
R 1 Yes
R 2 No
R 3 Not seen

NOT SEEN BY SOCIAL WORKER
R 1 Was seen
R 2 S.W. not aware when abortion scheduled
R 3 Patient refused to speak to S.W.
R 4 Worker absent from hospital
R 5 Other hospital emergency that Social Worker had to attend to
R 6 Language barrier
R 7 Patient cancelled
R 8 Other

PATIENT SPECIFICALLY NEEDED REASSURANCE RE DECISION FOR ABORTION

R 1 Yes
R 2 No
R 9 No answer

PATIENT HAD OTHER PROBLEMS

R 1 No
R 2 Yes
R 3 Needed referral to family or individual counseling agency
R 5 Need to speak with spiritual leader
R 6 Currently receiving help
R 9 No answer

PREVIOUS SPONTANEOUS ABORTION

R 1 No
R 2 1
R 3 2
R 4 3
R 5 4
R 6 5
R 7 6
R 9 No answer

PREVIOUS T. ABORTION

R 1 No
R 2 1
R 3 2
R 4 3
R 5 4
R 6 5
R 7 6
R 9 No answer
78
79    CASE NO.
80
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VITA

Beverly Freeman was born on July 13, 1937, in Painesville, Ohio, U.S.A. She obtained her elementary education at McKinley Public School in Fairport Harbor, Ohio. Her secondary education was completed in 1955 at Fairport Harding High School, Fairport Harbor, Ohio.

After studying sociology with an emphasis on social work, Mrs. Freeman graduated in 1959 with a General Arts, B.A. degree from Ohio University in Athens, Ohio. She then went on to complete a year, 1959-1960, of graduate social work training at Wayne State University in Detroit, Michigan. Her student placement was at the Family Service Bureau of Windsor (Ontario).

Mrs. Freeman accumulated a total of four years of work experience with the Children's Aide Society of the County of Essex in Windsor, Ontario from 1960 through 1966. She accepted a social work position with the Salvation Army Grace Hospital, Windsor, Ontario, in 1973. Mrs. Freeman obtained a year's leave of absence from the hospital to continue her education.

In 1975, she was accepted into the Master of Social Work program at the University of Windsor and expects to graduate in October, 1976. Mrs. Freeman's field placement as a M.S.W. candidate was with Windsor Western Hospital, IODE Branch in Windsor, Ontario.