

The nature and dynamics of coping with induced abortion in young adult women

R Lyon

 **orcid.org / 0000-0002-9657-5639**

Thesis submitted in fulfilment of the requirements for the degree
Doctor of Philosophy in Psychology at the North-West
University

Promoter: Prof KFH Botha

Assistant promoter: Dr LD Preston

Graduation: May 2019

Student number: 21057125

Solemn declaration

I, Roché Lyon, hereby declare that the thesis titled “*The nature and dynamics of coping with induced abortion in young adult women*” submitted to the North-West University, Potchefstroom Campus, in fulfilment of the requirements for the Ph.D. in psychology, is my own work, has not been submitted to any other university, and has been properly language edited.

I understand and accept that the copies that are submitted for examination are the property of the university.

Signature of student

.....
Roché Lyon
University number: 21057125

Letter of permission

Permission to submit the manuscript for degree purposes

The student is hereby granted permission to submit her thesis for the purpose of obtaining a Ph.D. degree in Psychology.

The student's work has been submitted to TurnItIn and a satisfactory report has been obtained.

Promoter



.....
Prof. K.F.H. Botha

Preface

Article format

This thesis was completed in fulfilment of the requirements for the completion of the doctorate degree in psychology. The thesis has been prepared according to the guidelines for a thesis in article format of the North-West University.

Journal

The articles were submitted for publication to the *South African Journal of Psychology* and were prepared in accordance with the author guidelines of the journal upon submission. However, the manuscripts are here presented according to the American Psychological Association (APA) publication guidelines for the purpose of examination.

Page numbers

This thesis is presented as a whole and is numbered as such. On submission for publication, each manuscript was numbered from page 1.

Note to the examiners

The tables and figures were included in the text in order to ease the readability of the thesis. This contributes to the fact that the articles extend the length as prescribed by the *South African Journal of Psychology*, but will be altered for publication purposes.

Guidelines for Authors

The South African Journal of Psychology publishes empirical, theoretical and review articles on all aspects of psychology.

Peer review policy

The South African Journal of Psychology operates a blind peer review process with each manuscript reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible and the editorial team strives for a decision within 8-10 weeks of submission, although this is dependent on reviewer availability. Where authors are invited to revise manuscripts for re-submission, the editor must be notified (by e-mail to sajp@psyssa.co.za) of their intention to resubmit and the revised manuscript should be re-submitted within four weeks.

Article types

The South African Journal of Psychology considers submissions addressing South African, African or international issues, including:

- Manuscripts reporting on research investigations
- Review articles focusing on significant issues in Psychology

New submissions should not exceed 5500 words, including references, tables, figures, etc. Authors of manuscripts returned for revision and extension should consult the Editorial Office regarding amended length considerations. All manuscripts should be written in English and include an abstract of not more than 250 words. The writing must be of a high grammatical standard, and follow the technical guidelines stipulated below. The publication guidelines of the American Psychological Association 6th edition (APA 6th) must be followed in the preparation of the manuscript. Manuscripts of poor technical or language quality will be returned without review.

Other conventions

Research ethics

Authors should specify the steps taken to facilitate ethical clearance – that is, the ways in which they comply with all ethical issues pertaining to their study, including obtaining informed consent. The manuscript must include the name of the institution that granted ethical approval for the research (if applicable).

Journal Style

The South African Journal of Psychology conforms to the SAGE house style. Research-based manuscripts should use the following format: The introductory/literature review section does not require a heading, thereafter the following headings /subheadings should be used: Method (Participants; Instruments; Procedure; Ethical considerations; Data analysis (which includes the statistical techniques or computerized analytic programmes, if applicable); Results; Discussion; Conclusion; References. The “Ethical considerations” section must include the name of the institution that granted the ethical approval for the study (if applicable).

Reference Style

The South African Journal of Psychology adheres to the APA reference style.

Manuscript Preparation

The text should be double-spaced throughout and with a minimum of 3 cm for left- and right-hand margins and 5 cm at head and foot. Text should be standard 12 point.

Keywords and Abstracts: Helping readers find your article online

Authors should include (a) an Abstract of up to 250 words and (b) up to 6 alphabetised keywords. The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information

and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on How to Help Readers Find Your Article Online.

Guidelines for submitting artwork, figures and other graphics

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's Manuscript Submission Guidelines. Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article. The inclusion of photographs is generally discouraged.

English Language Editing services

Non-English-speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit English Language Editing Services on our Journal Author Gateway for further information.

Acknowledgements

- Praise to the Lord for planting the seed in my heart to undertake this research study, for providing and for guiding every step of the way in His time.
- To Prof. Karel Botha, my promotor and research mentor, I have learned so much from you over the years. Your compassion for research is inspiring. Thank you for sharing your knowledge and motivation.
- To Dr. Lynn Preston, my co-promotor, thank you for all your assistance during the whole process, from getting approval to collecting the data. You have a heart of gold and your work at the hospital inspires many.
- To my husband, Marnus Lyon, my little girl Avileigh, and my baby boy Bordeaux, you are my world. Thank you for your love and support throughout this journey.
- To my parents, Francois and Louise Bornmann, thank you for your unconditional support and motivation.
- To the counsellors at the Potchefstroom Hospital, thank you for assisting me.
- To Sister Seobi, thank you for all your help with the research.
- To the language editor, Christien Terblanche, thank you for the language editing.

Summary

The nature and dynamics of coping with induced abortion in young adult women

This study was motivated by a strong appeal that more than two decades after the implementation of the Choice on Termination of Pregnancy Act (South Africa, 1996), the promise of access regarding pre- and post-abortion counselling is not yet translated into effective service delivery. In addition, there is a gap in the literature on how South African women experience and cope with induced abortion, as well as the extent to which coping interventions specifically emphasize the self-regulatory, agency-related aspects of coping.

The study consists of three substudies, reported in three manuscripts. Manuscript 1 aims to determine what international and South African literature is available on how women experience and cope with induced abortion and to determine to what extent their coping strategies reflect a sense of agency and self-regulation. It presents a rapid review using the guidelines of the National Institute for Health and Clinical Excellence (NICE) (2012) as basic framework and a narrative synthesis (Popay et al., 2006) to synthesize the results.

Manuscript 2 explores how a sample of young adult South African women who had undergone an induced abortion perceive the relationship between different aspects of their experience and coping, and to develop a conceptual model based on that. Interactive Qualitative Analysis (IQA) (Northcutt & McCoy, Interactive qualitative analysis. A systems method for qualitative research, 2004) was applied to obtain the findings.

Manuscript 3 conceptualizes and provides a stepwise development of counselling guidelines to facilitate effective coping skills in young adult women undergoing an induced abortion. Guidelines were developed according to the framework provided by Gagliardi, Marshall, Huckson, James and Moore, (2015) and Wight, Wimbush, Jepson and Doi (2016), based on the findings of manuscript 1 and manuscript 2.

Together, the three substudies found that an unwanted pregnancy and abortion is a complex, intertwined experience which challenges women and affects both their inter- and intra-personal relationships. They often experience a lack of support, negative emotions, isolation or rejection during the abortion process, while positive experiences were limited to relief and some meaning focused coping efforts. The unwanted pregnancy seems to be the starting point of an event that causes a discrepancy between where they want to be regarding important life goals and where they currently are. It motivates them, at the same time, to avoid others to protect themselves from rejection and judgement. The resulting lack of social support and absence of clear problem-focused coping efforts, contribute to the maintenance of negative experiences. It was argued that in order to facilitate psychological growth in these women, their general resources and coping skills should be fostered and broadened (Fredrickson, 2013).

In South African public hospitals where facilities are often lacking and stigma often thriving, counsellors could play an important role to set these women on psychological growth trajectories. Based on this, guidelines were developed that emphasize consideration of each woman's context within a combined person-centred and strengths approach to maximise the effectiveness of three proposed change mechanisms.

Keywords: coping, proactive coping, experience, induced abortion, termination of pregnancy, young / emerging adult, self-regulation, agency, rapid review, Interactive Qualitative Analysis.

Opsomming

Die aard en dinamika van die hantering van geïnduseerde aborsie in jong volwasse vroue

Hierdie studie is gemotiveer deur die besware oor die feit dat die belofte van toegang tot voorligting voor en na aborsie steeds nie lei tot effektiewe dienslewering meer as twee dekades na die bekragtiging van die Wet op die Beëindiging van Swangerskap (92 van 1996) nie. Daarbenewens is daar 'n gaping in die literatuur wanneer dit kom by hoe Suid-Afrikaanse vroue geïnduseerde aborsie ervaar en dit hanteer, en ook oor die mate waartoe hanteringsintervensies spesifieke self-regulerende, self-agentskapverwante aspekte beklemtoon.

Die studie bestaan uit drie substudies wat in drie manuskripte gerapporteer word. Manuskrip 1 het ten doel om te bepaal watter internasionale en Suid-Afrikaanse literatuur beskikbaar is oor hoe vroue geïnduseerde aborsie ervaar en tot watter mate hulle hanteringstrategieë 'n sin van self-agentskap en self-regulering reflekteer. Die manuskrip bied 'n sneloorsig aan die hand van die riglyne van die *National Institute for Health and Clinical Excellence* (NICE) (2012) as basiese raamwerk en 'n narratiewe sintese (Popay et al., 2006) om die resultate te integreer.

Manuskrip 2 ondersoek hoe 'n steekproef jong Suid-Afrikaanse vroue wat 'n geïnduseerde aborsie ondergaan het die verhouding tussen verskillende aspekte van hulle ervaring en hantering sien, en ontwikkel 'n konseptuele model gebaseer daarop. Interaktiewe kwalitatiewe analise (IKA) (Northcutt & McCoy, *Interactive qualitative analysis. A systems method for qualitative research*, 2004) is gebruik om die bevindinge te ontgin.

Manuskrip 3 konseptualiseer en bied 'n stapsgewyse ontwikkeling van voorligtingsriglyne om effektiewe hanteringsvaardighede onder jong vroue wat 'n

geïnduseerde aborsie ondergaan te fasiliteer. Die riglyne is ontwikkel volgens die raamwerk wat verskaf is deur Gagliardi, Marshall, Huckson, James en Moore, (2015) en Wight, Wimbush, Jepson en Doi (2016) en gebaseer op die bevindinge van Manuskrip 1 en Manuskrip 2.

Die drie substudies het gesamentlik bevind dat 'n ongewenste swangerskap en aborsie 'n komplekse, verweefde ervaring is wat vroue uitdaag en wat hulle inter- en intrapersoonlike verhoudinge affekteer. Hulle ervaar dikwels 'n gebrek aan ondersteuning, negatiewe emosies, isolasie of verwerping gedurende die aborsieproses. Positiewe ervarings was beperk tot 'n mate van verligting en enkele betekenisgefokusde hanteringsprosesse. Die ongewenste swangerskap blyk die beginpunt te wees van 'n gebeurtenis wat 'n diskrepansie veroorsaak tussen waar die vrou is en waar hulle wil wees met betrekking tot lewensdoelwitte. Dit motiveer hulle terselfdertyd om ander te vermy en hulleself te beskerm teen verwerping en veroordeling. Die gevolglike gebrek aan sosiale ondersteuning en die gebrek aan duidelike probleemgefokusde hanteringsprosesse dra by tot die voortsetting van negatiewe ervarings. Daar is 'n argument dat die vrou se algemene hulpbronne en hanteringsvaardighede versterk en verbreed moet word om psigologiese groei te fasiliteer (Fredrickson, 2013).

In Suid-Afrikaanse openbare hospitale waar fasiliteite dikwels tekort skiet en stigma dikwels seëvier, kan voorligters 'n belangrike rol speel om hierdie vroue op 'n baan van psigologiese groei te plaas. Gegewe hierdie feit, is riglyne ontwerp wat die inagneming van elke vrou se konteks binne 'n gekombineerde persoongesentreerde en sterktebenadering beklemtoon om sodoende die effektiwiteit van drie voorgestelde veranderingsmeganismes te maksimaliseer.

Sleutelwoorde: hantering, proaktiewe hantering, ervaring, geïnduseerde aborsie, beëindiging van swangerskap, jong / ontluikende volwassene, self-regulering, self-agentskap, sneloorsig, interaktiewe kwalitatiewe analise.

Table of Contents

Solemn declaration.....	i
Letter of permission.....	ii
Preface.....	iii
Guidelines for Authors	iv
Acknowledgements	vii
Summary.....	viii
Opsomming.....	x
Table of Contents	xiii
List of Tables	xix
List of Figures.....	xx
CHAPTER 1: INTRODUCTION, PROBLEM STATEMENT AND THE AIM AND	
OBJECTIVES OF THE STUDY.....	1
Introduction.....	1
Reasons for Induced Abortion.....	2
Psychological consequences of abortion.....	3
Coping, self-regulation and agency	4
Problem statement	9
Aims 11	
Overview of the methodology	11
Ethical considerations.....	12
Outline of the manuscript	12
References.....	13

CHAPTER 2: MANUSCRIPT 1	22
The experience of and coping with abortion: A rapid review.....	22
Abstract.....	23
The experience of and coping with an abortion: A rapid review	24
Methodology	27
Research Design	27
Keyword search strategy	28
Selection of studies to be included	29
Data extraction from the final group of selected articles	30
Data Analysis.....	30
Ethics and trustworthiness.....	30
Results	31
The Effect of Premorbid Factors on an Abortion Experience.....	44
Stressors related to an Abortion.....	44
Social stressors.....	44
Ambivalence or Conflict.....	45
Lack of autonomy and control.	45
Negative emotions experienced in relation to an Abortion.	46
Depression.	46
Anxiety.....	47
Physical and emotional pain.	48
Guilt. 48	
Coping with an Abortion.....	49
Self-Reflection: Trying to Make Sense of the Experience.....	49
Avoidance Coping.	50
Positive experiences.	50

Discussion 51

Limitations..... 55

Conclusion and future directions 56

References..... 58

CHAPTER 3: MANUSCRIPT 2 67

The experience and coping with an induced abortion of a group of South African women 67

Abstract..... 68

The experience and coping with induced abortion of a group of South African women 69

Methodology 73

Research Design 73

Participants..... 73

Ethics..... 75

Data collection and analysis 75

Results 78

Themes reflecting the experience of and coping with abortion. 78

Perceived relationship between the themes. 84

Discussion 96

Limitations..... 101

Conclusion and future research..... 102

References 105

CHAPTER 4: MANUSCRIPT 3 115

**Towards the development of guidelines to facilitate effective coping in young adult women
undergoing induced abortion in South Africa 115**

Abstract..... 116

Towards the development of guidelines to facilitate effective coping in young adult women	
undergoing induced abortion in South Africa	117
Method	120
Data collection and Analysis: Steps in the development of the guidelines.....	121
Define and understand the problem and its causes.	121
Clarify which causal or contextual factors are malleable and have the greatest scope for change.....	121
Identify how to bring about change: the theory and change mechanisms.	121
Identify how to deliver the change mechanism.	122
Ethics Issues and trustworthiness.....	122
Implementing and discussing the four steps of developing abortion counselling guidelines	123
Step 1 - Define and understand the problem and its causes.....	123
Step 2 - Clarify which causal or contextual factors are malleable and have the greatest	
scope for change.....	127
Step 3 - Identify how to bring about change: the theory and change mechanisms.....	128
Person-centred approach.....	128
Strengths perspective.	129
Change mechanisms.....	130
Change mechanism 1 – Counsellor’s ability to reflect on own possible biases.....	131
Change mechanism 2 – Understanding and reappraising context.	132
Change mechanism 3 – Promoting clients’ coping skills in an effective way.....	133
Step 4 - Identify how to deliver the change mechanism.	136
Limitations and the way forward	138
Conclusion	139
References.....	141

CHAPTER 5 SUMMARY, CONCLUSION, AND RECOMMENDATIONS...	151
Introduction.....	151
Chapter 2 / Manuscript 1	152
Chapter 3 / Manuscript 2:	154
Chapter 4 / Manuscript 3	156
Limitations.....	159
Integrated conclusion.....	160
Contribution of the study	161
Recommendations for further research.....	162
References	164
Combined Reference List	169
ADDENDUM 1	194
Informed Consent – Stage 1	194
Informed Consent – Stage 2.....	199
ADDENDUM 2	204
Questionnaire.....	204
ADDENDUM 3	210
Guidelines to facilitate effective coping in young adult women undergoing legal induced abortion	210
Index	211
Introduction: context, prerequisites and ethics.....	212
Theoretical approach.....	217

The person-centred approach.....	217
The strengths approach.....	219
Change mechanisms.....	220
Guideline 1 – <i>The counsellor’s ability to reflect on his or her own biases.....</i>	220
Guideline 2 – <i>Understanding and reappraising context.....</i>	222
Guideline 3 – <i>Promoting clients’ coping skills in an effective way.....</i>	223
Summary:	225
References.....	226
ADDENDUM 4	230
Declaration of Language Editing.....	230

List of Tables

Table 1: Data Extraction of the Eleven Eligible Studies.	33
Table 2: Biographical information of participants.....	74
Table 3: Categories and themes identified.....	79
Table 4: Frequency and power analysis of the relationships between themes.	85
Table 5: Inter-relational Diagram (IRD).....	93
Table 6: Themes related to the experience of and coping with abortion.....	124
Table 7: A summary of the three change mechanisms in relation to the theoretical approach	131
Table 8: Terminology	213
Table 9: A summary of the three change mechanisms in relation to the theoretical approach	225

List of Figures

Figure 1: Search Flow Chart: Realization of Search Strategy	29
Figure 2: Power analysis.....	92
Figure 3: Tentative SID	94
Figure 4: Cluttered SID.....	94
Figure 5: Final SID	95

CHAPTER 1: INTRODUCTION, PROBLEM STATEMENT AND THE AIM AND OBJECTIVES OF THE STUDY

Introduction

Besides spontaneous abortion or miscarriage, abortion can be divided into two categories, namely therapeutic abortion, which refers to an abortion to prevent damage to the mother's health, and non-therapeutic or elective abortion, also known as induced abortion or abortion upon request (UnitedHealthcare, 2017). Induced abortion is therefore a medically induced miscarriage using pharmacological means and/or surgical procedures (Torriente, Joubert, & Steinberg, 2016). In this study, "abortion" refers to legal induced abortion. Today, health workers prefer the term termination of pregnancy above the term abortion, but abortion is still used in most references and in the South African health context.

Abortion has been legal in South Africa since the Choice on Termination of Pregnancy Act (92 of 1996), was promulgated in November 1996 (South Africa, 1996). The act was amended in 2008 and is now known as the Choice on Termination of Pregnancy Amendment Act (1 of 2008) (South Africa, 2008). The act was amended to recognize that the state is responsible for providing reproductive health to all and for providing a safe environment where the freedom of choice can be exercised without fear or harm. In addition, the act's goal is to help victims of rape or incest and women who could be significantly affected socially and economically by the pregnancy. Although the act enables women in South Africa to make critical decisions regarding their pregnancies, it strongly states that abortion is not a form of contraception or population control. The act further states that abortion should be provided upon request until the end of the first trimester (the first 12 weeks of pregnancy), under certain circumstances between 13 and 20 weeks of gestation, and only under limited circumstances after 20 weeks of gestation. The act further stipulates that

non-mandatory and non-directive pre- and post-abortion counselling should be provided together with the mandatory provision of the necessary information to women seeking abortion to enable them to make an informed decision (South Africa, 2008). The act allows women to receive a free abortion in a public hospital or clinic, which prevents the morbidity and mortality associated with unsafe illegal abortions.

Abortion is a common medical intervention and an important component of public health (American Public Health Association, 2015; The American College of Obstetricians and Gynaecologists, 2014). However, it is difficult to obtain abortion statistics mainly due to the nature of abortion (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018). The latest modulated international statistics on abortion incidence (both legal and illegal) available indicates that between 2010 and 2014 an estimated 36 abortions occurred each year per 1000 women between the ages of 15 and 44 years in developing regions (i.e. South Africa) and 27 abortions per 1000 women in developed regions (Singh, Remez, Sedgh, Kwok, & Onda, 2018). In 2017, 73 072 abortions were performed in South Africa's legal state health facilities (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018).

Reasons for Induced Abortion

The decision to terminate a pregnancy is among the most personal and socially opposed of all health decisions that women make (Foster, Gould, Taylor, & Weitz, 2012). The daily torrent of articles in the media around the world reveals that this elective procedure evokes a great deal of emotion, moral passion and discordant political debates.

Although the reasons for abortions differ greatly, the primary reason why women worldwide seek abortion is an unplanned or unwanted pregnancy (Ndwambi & Govender, 2015; Singh et al., 2018). However, women's motivations for choosing to terminate a pregnancy seem to be much more complicated than just not wanting a baby. The major

grounds seem to centre around not being emotionally prepared or being too young and immature (Ndwambi & Govender, 2015; Ngene, Ross, & Moodley, 2013); financial constraints; relational problems with the partner (including violence and sexual assault); the need to complete studies; interference with future plans; fear of parental reaction; and being pressured into having a termination (Madiba & Nekhumbe, 2014; Ndwambi & Govender, 2015). Lince-Deroche, Fetters, Sinanovic and Blanchard (2017) also report that one of the main grounds for having an abortion is financial concerns. Although emotional immaturity and financial reasons may reflect women's desire to optimize their own quality of life and well-being and to take charge of their own lives and future, it could also possibly indicate their concern for the negative quality of life they anticipate for the unborn baby. This clearly indicates that selfishness is not the only motivation, but that abortion may also be perceived as the only way to prevent the child from having a difficult life. The complexity of relationship problems and even violence could add to the mother's fears and uncertainty and exacerbate the difficulty she faces when considering an abortion.

Psychological consequences of abortion

The psychological effects of abortion have been researched extensively, but these efforts have produced inconsistent results. Numerous articles on abortion and mental health state no causal link between abortion and subsequent mental illness (Charles, Polis, Shridhara, & Blum, 2008; APA, 2008; National Collaborating Centre for Mental Health (NCCMH), 2011; Robinson, Stotland, Russo, Lang, & Occhiogrosso, 2009; Steinberg & Russo, 2009; Van Ditzhuijzen et al., 2017). In addition, Quinley, Ratcliffe and Schreiber (2014) found that not only do women do well psychologically in the immediate period following abortion, but their psychological state as a whole improved.

On the other hand, some studies suggest that women do experience psychological distress after having an abortion. However, some authors are of the opinion that women's reactions after induced abortion cannot be separated from their pre-abortion mental health (Steinberg, Tschann, Furgerson, & Harper, 2016). Van Ditzhuijzen et al. (2015) support this by pointing out that it is often unknown to what extent the distress a woman experiences after an abortion is related to the abortion or to the unwanted pregnancy. This means that the abortion and the unwanted pregnancy cannot be separated (Van Ditzhuijzen et al., 2017). The experience of psychological distress is further linked to a range of contextual factors such as the unique and different backgrounds of each woman (Major, et al., 2009); the abortion stigma; the legality and morality of having an abortion; waiting periods and mandatory ultrasound viewing (Norris, et al., 2011); pre-existing mental health problems; pressure from a partner to have an abortion; negative attitudes in general; and the woman's personal experience of the abortion (NCCMH, 2011).

It is therefore no surprise that Cameron (2010) indicates that the question whether abortion has a negative effect on the mental health of the woman is a recurring one with no clear answers. What is certain, however, is that abortion is a process with several difficult, ever-changing challenges, and that the outcome would depend on the ability to effectively cope with and manage these challenges. Long-term mental health does not imply the absence of challenges, but rather involves effectively dealing with them.

Coping, self-regulation and agency

The theoretical framework of this study is based on proactive coping, a human strength that reflects constructive and goal-directed engagement with stressors and life challenges. Proactive coping is considered a self-regulatory process during which the individual takes responsibility for his or her own change processes, often referred to as

“agency” (Bandura, 2008; 2018). Although the concept of coping has always been linked to stress (Straud, Mcnaughton-Cassill & Fuhrman, 2015), the inclusion of the concept in research has made an important contribution to understanding human behaviour well beyond the original goals of coping research (Frydenberg, 2014).

Coping is perhaps still best defined by Lazarus and Folkman in the 1980s. They referred to coping as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person” (1984, p. 141). Although the science of coping has developed significantly since then, the leading researchers in the field still regard their definition as relevant and significant today. Since the early work by Lazarus and Folkman, different models and approaches to coping behaviour have been developed, of which the two most notable are the transactional (based on Lazarus & Folkman, 1984) and the conservation of resources (Hobfoll, 2010) approaches. A central assumption to both these approaches is that the cognitive appraisal of the stressor plays an essential role, with a differentiation between primary appraisal (the process through which an individual perceives a situation as relevant or threatening) and secondary appraisal (the process through which the individual evaluates his or her available resources as either lacking or sufficient to solve or manage the situation) (Lazarus, 1991; Snyder & Dinoff, 1999). In the conservation of resources approach, Hobfoll (2010) emphasizes the individual’s ability to shift the focus of attention away from loss by reinterpreting a threat as a challenge. Based on the appraisal process, the individual’s coping strategy can be described as either problem-focused (efforts to solve the goal-threatening condition through action), emotion-focused (efforts to decrease negative feelings resulting from distress) (Lazarus, 1991; De Ridder & Kuijer, 2006) or meaning-focused (efforts to create meaning from distress) (Frydenberg, 2014).

Traditionally, coping was seen as a reactive process or a response to a stressor that has already occurred or is in process of occurring. Later researchers in the field of positive psychology and coping have explored alternative ways of coping that may promote positive adaptation to stressors. As a result, it has become clear that it is possible for a person to cope before a stressful event takes place (Aspinwall & Taylor, 1997; Schwartz & Taubert, 2002). This is known as proactive or preventive coping. It is defined as the efforts to prevent a potentially stressful event or to modify its form before it occurs (Aspinwall & Taylor, 1997); the ability to identify potential sources of stress before they occur; or as a method of assessing future goals and setting the stage to achieve these goals effectively (Schwartz & Taubert, 2002). In addition, proactive coping is focused on developing resources to address challenges and pursue personal growth. Preventive coping involves building up resources to minimize negative outcomes (Greenglass, 2002; Schwarzer, 2001). Although some researchers (for example Drummond & Brough, 2016; Sohl & Moyer, 2009) differentiate between proactive and preventive coping, revealing two distinct factors, results are inconsistent and further research is needed.

Schwartz (2001) states that proactive coping differs from reactive coping in three key ways. Firstly, reactive coping deals with stressful events that have already occurred. The goal is to compensate for past harm or loss, while proactive coping is more future orientated. Secondly, reactive coping involves risk management, while proactive coping is based on goal management. Lastly proactive coping's motivation is more positive because it results from perceiving situations as challenging rather than threatening. Proactive coping entails several potential benefits, therefore it can minimize the degree of stress experienced in a stressful situation and promote positive adaptation to stressors. If a stressful situation is a possibility

rather than an actuality, proactive coping can lessen its impact so that it may never be experienced (Schwarzer, 2001).

As a result of this focus on proactive coping, research on coping has started to interlink with research on self-regulation and agency as human strengths. Carver, Scheier and Fulford (2008) argue that stress and coping should be viewed within the broader context of self-regulation, as it promises to yield a deeper and broader understanding of the nature of stress and coping. Self-regulation refers to those systemic processes involved in setting, attaining and maintaining personal goals (Maes & Karoly, 2005; Vancouver & Day, 2005). Furthermore, self-regulation also refers to the changes that one makes to work towards achieving goals, including managing hindrances or urges that might obstruct attaining these goals (Carver & Scheier, 2016). According to Bandura (2001), self-regulation enables people to play a part in their self-development, adaptation and self-renewal within changing contexts. An individual with good self-regulation has the ability not only to alter their own behaviour and responses effectively (Peterson & Seligman, 2004), but also to act proactively and anticipatorily (Bandura, 2001) towards goal attainment. Self-regulation can be categorized into three groups, namely behavioural, cognitive and emotional. Behavioural self-regulation refers to regulating actions and impulsivity, cognitive self-regulation involves planning, organizing, motivation and attention, while emotional self-regulation consists of regulating feelings and emotions (Healey et al., 2018). The key phases in self-regulation consist of goal establishment, goal execution, self-monitoring and the adjustment of a behaviour or goal (Carver, 1979; Carver & Scheier, 2016; Vancouver & Day, 2005). Ongoing self-monitoring is a key self-regulation process in coping – it helps the individual to compare current behaviour with goals and to implement changes if discrepancies are perceived (Sniehotta, 2009). As coping also reflects an effort to reinstate intended goal states, the link

between coping and self-regulation makes perfect sense. Sohl and Moyer (2009) specifically perceive proactive coping as a form of self-regulation as it involves assessing and setting future goals and preparation for future stressors.

A central principle in self-regulation and proactive coping is that of agency. Bandura (2018) defines agency as the individual's ability to make things happen by means of his/her own ("self") actions. The ability to make things happen through "self" actions enables an individual to rise above social pressure and be in control of shaping their environments and life courses (Bandura, 2008). According to Little, Hawley, Henrich and Marsland (2002), agency refers to volitional, goal-directed behaviour. Individuals are active agents who plot and navigate a chosen course through the uncertainties and challenges of their social contexts. Individuals engage in a self-evaluative feedback process in an effort to be effective in this regard, continuously interpreting and evaluating actions and their consequences. As a result, they continually discover and refine who they are and what they are capable of. Effective agency is therefore dependent on the interconnection and organization within oneself and one's capacity to correct and regulate oneself (Tyson, 2005).

In terms of coping with an unwanted pregnancy, a self-regulation perspective implies proactively anticipating the challenges one has to meet after the abortion and making appropriate changes in one's own behaviour to lessen the impact of those challenges. Self-regulation is the ability to manage, for example, the discrepancy between being pregnant with a child the individual is not able to care for and the goal of being pregnant with a child she is able to care for. A critical factor would be how the experience of this discrepancy affects the individual's sense of agency. Theoretically, a sense of agency would be possible if the person copes by being proactive and self-evaluative; if she is able to make appropriate changes to her own behaviour to such an extent that she has access to choice; if she is able to learn from

failures and to disengage from goals no longer attainable (Heckhausen, Wrosch, & Schultz, 2010), and overall, if she is able to enhance a sense of well-being.

Problem statement

According to Jane Harries, director of the Women's Health Research Unit at the University of Cape Town, South Africa's abortion law is probably the most progressive in the world (Moore & Ellis, 2013). However, it is clear that more than two decades after the implementation of the Choice on Termination of Pregnancy Act, (92 of 1996) (South Africa, 1996) the promise of access does not necessarily translate into services that are available (Moore & Ellis, 2013, Vincent, 2012). Many successes were achieved during the early days of South Africa's democracy, yet less than one third of trained health providers actually provide service (Trueman & Magwetshu, 2013). A survey conducted by the Bhekisisa organization (2017) found that South Africa has 5 048 public health facilities where abortions could potentially be offered, yet only 197 provide abortion services. The shortage of abortion services pertains to both the abortion itself and pre- and post-abortion counselling services. This is of great concern. Moreover, abortion is so stigmatized that even when legal abortion services are available, women often face humiliation and judgement when requesting an abortion (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018). The lack of access to facilities and stigma mean that women need to travel long distances to facilities that do provide legal abortions, or even worse, they consult illegal abortion providers (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018). The challenge regarding access to abortion services is further discussed by Lince-Deroche et al. (2017). One can only assume that since abortion services are not as readily available as they should be, women who request abortion services do not receive the counselling services prescribed by the law. Furthermore, Skosana (2014) indicates that abortion health care providers in South Africa often show

opposition to abortion and struggle to separate their personal beliefs from the service that they should provide. It is therefore not surprising that Skosana (2014) concludes that women are often traumatized by abortion health care providers in South Africa. As a result, there is a strong emphasis on the need for more research and the development of better quality abortion counselling skills in South Africa (Birdsey, Crankshaw, Mould & Ramklass, 2016; Mavuso, Du Toit, & Macleod, 2017; Vincent, 2012).

In addition, there is a gap in the literature on how South African women experience induced abortion, the strategies they use to cope with induced abortion and what role agency plays in the longer-term outcomes of their coping efforts. In conjunction with this, the extent to which coping interventions specifically emphasize the self-regulatory, agency-related aspects of coping also seem to be neglected. It is therefore not known to what extent current models of coping with induced abortion are valid and applicable to the South African context. Although a number of psychological interventions for induced abortion are described in the literature (compare Curley, 2010; Upadhyay, Cockrill & Freedman 2010), most of these seem to be without a dedicated coping focus. They are based on generic coping skills or are fragmented (e.g. a combination of support and cognitive-behavioural skills). In summary, women who choose to undergo induced abortions need effective coping skills to prevent long-term psychological damage and to enhance long-term psychological well-being. However, there is a lack of research, specifically in the South African health context, on how proactive coping as self-regulatory skill may contribute to a sense of agency in young women who had undergone an induced abortion. The unfulfilled needs and isolation women experience during and after induced abortion therefore necessitates an exploration of the role proactive coping, specifically from a self-regulatory perspective, could play in empowering these women to face their challenges and to prevent long-term negative effects.

Aims

The general aim of this study is to explore how young adult women experience and cope with induced abortion. The specific aims are to:

- determine what international and South African literature is available on how women experience and cope with induced abortion and to determine to what extent their coping strategies reflect a sense of agency and self-regulation;
- explore how a sample of young adult South African women who had undergone an induced abortion perceive the relationship between different aspects of their experience and coping, and to develop a conceptual model based on that; and
- conceptualize and develop counselling guidelines to facilitate effective coping skills in young adult women undergoing an induced abortion.

Overview of the methodology

Manuscript 1 presents a rapid review of current international and national literature on the experience of induced abortion using the guidelines of the National Institute for Health and Clinical Excellence (NICE) (2012) as a basic framework. A narrative synthesis (Popay et al., 2006) was conducted to synthesize the results from the retrieved articles. Manuscript 2 reports on Interactive Qualitative Analysis (IQA) (Northcutt & McCoy, 2004) based on an explorative research design to determine how a sample of young adult South African women who had undergone an induced abortion perceives the relationship between different aspects of their experience and coping. Manuscript 3 presents a stepwise development of guidelines (according to Gagliardi, Marshall, Huckson, James & Moore, 2015; Wight, Wimbush, Jepson & Doi, 2016) to facilitate effective coping in young adult women undergoing an induced abortion, based on the findings of manuscript 1 and manuscript 2.

Ethical considerations

Ethics approval for this study was obtained from the Health Research Ethics Committee of the North-West University (ethics approval number NWU-00059-16-S1). For phase 2 the study was additionally approved by the Health Department of South Africa, the Potchefstroom Hospital and registered on the National Health Research Database. Specific ethical consideration for each phase of the study will be presented in the 3 manuscripts.

Outline of the manuscript

Chapter 1 provides an introduction, the problem statement and the aims of the study.

Chapter 2 presents Manuscript 1, which addresses aim 1.

Chapter 3 presents Manuscript 2, which addresses aim 2.

Chapter 4 presents Manuscript 3, which addresses aim 3.

Chapter 5 concludes the study and offers recommendations for further research.

References

- American Psychological Association (APA) Task force on Mental Health and Abortion. (2008). Report of the APA Task Force on Mental Health and Abortion. *APA Task Force on Mental Health and Abortion*.
- American Public Health Association.(2015, November 3). *Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention*. Retrieved from American Public Health Association for science. for action. for health: <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights>
- Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin*, *121*, 417-436.
- Bandura, A. (2001). Social Cognitive Theory: An agentic perspective. *Annual Review of Psychology*, *52*, 1-26.
- Bandura, A. (2008). The reconstrual of "free will" from the agentic perspective of social cognitive theory. In J. Baer, J. C. Kaufman, & R. F. Baumeister, *Are we free? Psychology and free will* (pp. 86-127). Oxford: Oxford University Press.
- Bandura, A. (2018). Toward a Psychology of Human Agency: Pathways and Reflections. *Association for Psychological Science*, *13*(2), 130-136.

- Bhekisisa Mail and Guardian Centre for Health Journalism. (2018, June 18). *Sexual and Reproductive Justice Coalition*. Retrieved from Abortion in South Africa: http://srjc.org.za/wp-content/uploads/2018/06/i8jNT5fVReGoh4Uray3r_Bhekisisa_SafeAbortion_final_2018.pdf
- Birdsey, G., Crankshaw, T. L., Mould, S., & Ramklass, S. S. (2016). Unmet counselling need amongst women accessing an induced abortion service in Kwazulu-Natal, South Africa. *Contraception, 94*, 473-477.
- Cameron, S. (2010). Induced abortion and psychological sequelae. Best Practice and Research . *Clinical Obstetrics and Gynecology, 24*, 657-665.
- Carver, C. S. (1979). A cybernetic model of self-attention processes. *Journal of Personality, 37*, 1251-1281.
- Carver, C. S., Scheier, M. F., & Fulford, D. (2008). Self-regulatory processes, stress and coping. In O. John, R. Robins, & L. Pervin, *Handbook of personality. Theory and research*. (3rd ed., pp.725-742). New York: Guilford Press.
- Carver, C. S., & Scheier, M. F. (2016). Self-regulation of action and affect. In K. D. Vohs, & R. F. Baumeister, *Handbook of self-regulation: Research, theory, and applications* (3rd ed., pp. 3-23). Guilford Press.
- Charles, V. E., Polis, C. B., Shridhara, S. K., & Blum, R. W. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception, 78*(6), 436-450.
- Choice on Termination of Pregnancy Act, 92 of 1996 see South Africa (1996).

Choice on Termination of Pregnancy Amendment Act, 1 of 2008 see South Africa (2008).

Curley, M. (2010). *Psychological distress after abortion among university students:*

Developing an intervention (Vol. 72). Montreal: ProQuest Information & Learning.

De Ridder, T. D., & Kuijer, R. G. (2006). Managing Immediate Needs in the Pursuit of

Health Goals: The Role of Coping in Self-Regulation. In D. De Ridder, & J. De Wit,

Self-regulation in Health Behavior (p. 247). Chichester: John Wiley.

Drummond, S., & Brough, P. (2016). Proactive coping and preventive coping: Evidence for

two distinct constructs? *Personality and Individual Differences*, 92, 123-127.

Foster, D. G., Gould, H., Taylor, J., & Weitz, T. A. (2012). Attitudes and decision making

among women seeking abortions at one U.S. clinic. *Perspectives on Sexual and*

Reproductive Health, 44(2), 117-124.

Frydenberg, E. (2014). Coping research: Historical background, links with emotion, and new

research directions on adaptive processes. *Australian Journal of Psychology*, 66, 82-

92.

Gagliardi, A.R., Marshall, C., Huckson, S., James, R., & Moore, V. (2015). Developing a

checklist for guideline implementation planning: review and synthesis of guideline

development and implementation advice. *Implementation Science*, 10(19), 1-9.

Greenglass, E. R. (2002). Proactive Coping. In E. Frydenberg, *Beyond coping: Meeting*

goals, vision and challenges (pp. 37-62). London: Oxford University Press.

Healey, D., Gray, A. R., Chae, M., Taylor, B. J., Lawrence, J., Reith, D. M., & Wheeler, B. J.

(2018). The role of parent and child self-regulation in children's glycemic control.

Health Psychology, 37(4), 326-333.

- Heckhausen, J., Wrosch, C., & Schultz, R. (2010). A Motivational Theory of Life-Span Development. *Psychological Review*, *117*(1), 32-60.
- Hobfoll, S. E. (2010). Conservation of resources theory: Its implication for stress, health, and resilience. *The Oxford Handbook of Stress, Health, and Coping*, 127–147.
doi:10.1093/oxfordhb/9780195375343.013.0007
- Lazarus, R. S. (1991). *Emotion and Adaption*. New York: Oxford University Press.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Lince-Deroche, N., Fetters, T., Sinanovic, E., & Blanchard, K. (2017). Accessing medical and surgical first-trimester abortion services: women's experiences and costs from an operations research study in KwaZulu-Natal Province, South Africa. *Contraception*, *96*(2), 72-80.
- Little, T. D., Hawley, P. H., Henrich, C. C., & Marsland, K. W. (2002). Three Views of the Agentic Self: A Developmental Synthesis. In E. L. Deci, & R. M. Ryan, *Handbook of Self-Determination Research* (p. 470). New York: University of Rochester Press.
- Madiba, S., & Nekhumbe, T. (2014). Life circumstances and reasons that compel women to seek termination of pregnancy in Vhembe district. *African Journal for Physical, Health Education, Recreation and Dance*, *1*(1), 58-73.
- Maes, S., & Karoly, P. (2005). Self-regulation and intervention in physical health and illness: a review. *Applied Psychology: an international review*, *54*(2), 267-299.
- Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and Mental Health. *American Psychologist*, *64*(9), 863-890.

- Mavuso, J. M., du Toit, R., & Macleod, C. I. (2017, September). *Critical Studies in Sexualities and Reproduction Research Programme*. Retrieved from Rhodes University:
https://www.ru.ac.za/media/rhodesuniversity/content/criticalstudiesinsexualitiesandproduction/documents/20180926_PolicyBrief_PreAbortionCounselling.pdf
- Moore, J., & Ellis, E. (2013, January 21). *In South Africa, A Liberal Abortion Law Doesn't Guarantee Access*. Retrieved from The Nation:
<https://www.thenation.com/article/south-africa-liberal-abortion-law-doesnt-guarantee-access/>
- National Collaborating Centre for Mental Health (NCCMH). (2011, December). *Induced Abortion and Mental Health: a Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors*. *Academy of Medical Royal Colleges*. Retrieved from Academy of Medical Royal Colleges:
http://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf
- National Institute for Health and Clinical Excellence (NICE). (2012). *Methods for the development of NICE public health guidance*. Retrieved from National Institute for Health and Clinical Excellence: <http://www.nice.org.uk/about>
- Ndwambi, A., & Govender, I. (2015). Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal South Africa. *Southern African Journal of Infectious Diseases*, 30(4), 129-133.

- Ngene, N. C., Ross, A., & Moodley, J. (2013). Characteristics of women having first-trimester termination of pregnancy at a district hospital in Kwazulu-Natal. *South African Journal of Epidemiol Infect*, 28(2), 102-105.
- Norris, A., Bessett, D., Steinberg, J. R., Kavannaugh, M. L., de Zordo, S., & Becker, D. (2011). Abortion stigma: a reconceptualization of constituents, causes and consequences. *Womens Health Issues*, 21(3), 49-54.
- Northcutt, N., & McCoy, D. (2004). *Interactive qualitative analysis. A systems method for qualitative research*. London: Sage.
- Peterson, C., & Seligman, M. E. (2004). Self-Regulation. In C. Peterson, & M. E. Seligman, *Character Strengths and Virtues. A handbook and classification* (pp. 510-513). Oxford: Oxford University Press.
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme*. Lancaster University.
- Quinley, K., Ratcliffe, J., & Schreiber, C. (2014). Psychological coping in the immediate post-abortion period. *Journal of Women's Health*, 23(1), 44-50.
- Robinson, G. E., Stotland, N. L., Russo, N. F., Lang, J. A., & Occhiogrosso, M. (2009). Is there an "abortion trauma syndrome"? Critiquing the evidence. *Harvard Review of Psychiatry*, 17, 268-290.
- Schwarzer, R. (2001). Stress, resources and Proactive Coping. *International Association for Applied Psychology*.

- Schwartz, R., & Taubert, S. (2002). Tenacious goal pursuits and striving toward personal growth: Proactive coping. In E. Frydenberg, *Beyond coping: Meeting goals, visions and challenges* (pp. 19-35). London: Oxford University Press.
- Singh, S., Remez, L., Sedgh, G., Kwok, L., & Onda, T. (2018, March). *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. Retrieved from Guttmacher Institute: <https://www.guttmacher.org/report/abortion-worldwide-2017>
- Skosana, I. (2014, September 26). *Abortion turns into a nightmare*. Retrieved from Mail and Gaurdian Africa's Best Read: <http://mg.co.za/article/2014-09-26-abortion-turns-into-a-nightmare>
- Sniehotta, F. (2009). Towards a theory of intentional behaviour change: Plans, planning, and self-regulation. *British Journal of Health Psychology*, *14*, 261-273.
- Snyder, C. R., & Dinoff, B. L. (1999). Coping. Where have you been? In C. R. Snyder, *Coping*. New York: Oxford University Press.
- Sohl, S. J., & Moyer, A. (2009). Refining the Conceptualization of an Important Future-orientated Self-Regulatory Behavior: Proactive Coping. *Personality and Individual Differences*, *47*(2), 139-144.
- South Africa. (1996). *Choice on Termination of Pregnancy Act*, 92 of 1996. Pretoria: Government Printer.
- South Africa. (2008). *Choice on Termination of Pregnancy Amenment Act*, 1 of 2008. Pretoria: Government Printer.

Steinberg, J. R., & Russo, N. F. (2009). Evaluating research on abortion and mental health.

Contraception, 80, 500-503.

Steinberg, J. R., Tschann, J. M., Furgerson, D., & Harper, C. C. (2016). Psychological factors and pre-abortion psychological health: The significance of stigma. *Social Science and Medicine, 150*, 67-75.

Straud, C., Mcnaughton-Cassill, M., & Fuhrman, R. (2015). The role of the five factor model of personality with proactive coping and preventative coping among college students. *Personality and Individual Differences, 83*, 60-64.

The American College of Obstetricians and Gynecologists. (2014, November). *Increasing Access to Abortion*. Retrieved from The American College of Obstetricians and Gynecologists: Women's Health Care Physicians: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>

Torriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, Sout Africa. *Africa Journal of Nursing and Midwifery, 119-131*.

Trueman, K. A., & Magwetshu, M. (2013). Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa. *American Journal of Public Health, 397-399*.

- Tyson, P. (2005). Affects, Agency, and Self-regulation: Complexity theory in the treatment of children with anxiety and disruptive behavior disorders. *Journal of the American Psychoanalytic Association, 53*(1), 159-187.
- UnitedHealthcare. (2017). *Abortions (Therapeutic and Elective)*. Oxford: Oxford Health Plans, LLC.
- Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010). Informing Abortion Counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Education and Counseling, 81*, 415-421.
- van Ditzhuijzen, J., ten Have, M., de Graaf, R., Lutig, P., van Nijnatten, C. H., & Vollebergh, W. A. (2017). Incidence and recurrence of common mental disorders after abortion: Results from a prospective cohort study. *Journal of Psychiatric Research, 84*, 200-206.
- Vancouver, J. B., & Day, D. V. (2005). Industrial and organisational research on self-regulation: from constructs to applications. *Applied Psychology, 54*(2), 155-185.
- Vincent, L. (2012). Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order - a view from South Africa. *Culture, Health and Sexuality, 14*(2), 125-138.
- Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2016). Six steps in quality intervention development. *Journal of Epidemiological Community Health, 70*(5), 520-525.

CHAPTER 2: MANUSCRIPT 1

The experience of and coping with abortion: A rapid review

R. Lyon & K.F.H. Botha

School for Psychosocial Health, North-West University: Potchefstroom Campus

R. Lyon *

3078 Fish Eagle Ave, Parys Golf & Country Estate

Parys

9585

roche.lyon@gmail.com

*To whom correspondence should be addressed

Running head: SYSTEMATIC REVIEW

The Experience of and Coping with an Abortion: A Rapid Review

Abstract

A rapid review was conducted to determine the scientific evidence available on how women experience and cope with abortion. From an initial total of 537 articles, 11 articles were identified as eligible for inclusion in this research. A narrative synthesis was conducted to synthesize the findings across the 11 final articles. Results indicate that women who had abortions reported different experiences and ways of coping. Five broad themes were identified, namely premorbid factors, stressors, negative emotions, coping strategies and positive experiences. Premorbid factors such as personality, poverty and partner violence influenced the abortion experience. Stressors reported include stigma, lack of support, ambivalence or conflict, and a lack of autonomy or control. Negative emotions such as depression, anxiety, pain and guilt were reported by most studies, while coping efforts almost exclusively included self-reflection and avoidance coping. Both a sense of relief and autonomy may represent a form of self-protection against resource loss from a conservation of resources perspective.

Keywords

Coping, abortion, termination of pregnancy, stress, self-regulation, rapid review

The experience of and coping with an abortion: A rapid review

Unintended and unwanted pregnancies occur in all societies regardless of medical, financial, educational or religious status (Torriente, Joubert, & Steinberg, 2016). It is therefore no surprise that approximately 90% of abortions are induced, that is, performed due to unintended or unwanted pregnancies (Templeton & Grimes, 2011) in contrast to spontaneous abortion, miscarriage or abortion to prevent damage to the mother's health. In South Africa alone, 73 072 abortions were performed in legal state health facilities in 2017 (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018).

While there has been a notable increase in the number of studies available on abortion, contradictory evidence is presented on how women experience and cope with abortion. According to Suffla (1997) and Thobejane (2001), there is no painless way of dealing with an unwanted pregnancy. This is supported by findings from South African research. Mojapelo-Batka and Schoeman (2003) found that most women experienced moral conflict and negative emotions about their abortion decision, while Mookamedi, Mogotlane and Roos (2015) report feelings of regret, guilt, self-blame, judgement and physical pain in women after abortion. Abortion can however, also be a means of resolving the stress associated with the unwanted pregnancy and may lead to relief rather than inevitable negative psychological experiences or long term mental health problems (Major et al., 2009). This is supported by among others, Subramaney et al. (2015), in a South African longitudinal study on depressive and posttraumatic stress symptoms following abortion, who found that women may not necessarily become depressed, nor experience short- or medium-term trauma.

To complicate matters further, a systematic review conducted by the National Collaborating Centre for Mental Health (NCCMH) (2011) concluded that there are significant limitations in the evidence examining the relationship between unwanted

pregnancy, abortion and mental health and there are many variables that influence this relationship. Charles, Polis, Shridhara, and Blum (2008) further indicate that while studies with flawed methodologies tend to find negative mental health sequelae of abortion, higher quality studies suggest few, if any, mental health differences between women who had abortions and their respective comparison groups. According to the American College of Pediatricians (2018) research on abortion is often accompanied by research bias. Many researchers who are in favour of abortion tend to downplay the consequences of abortion, while those who oppose abortion tend to emphasize the consequences of abortion. It is therefore clear, despite the suggestion by Robinson et al. (2009) that the most reliable predictor of post-abortion health is mental health prior to abortion, that we still don't have a clear and scientific understanding of the experience of abortion, or factors that influence the long-term mental health outcomes thereof.

Due to the nature and potential physical and psychological impact of abortion, it is closely associated with the experience of stress (World Health Organization [WHO], 2008). According to transactional approaches to stress and coping, stress emerges from an interaction between the person and the environment (Billings & Moos, 1981; Lazarus & Folkman, 1984, Frydenberg, 2014). More specifically, stress emerges from situations that the person appraises as taxing or exceeding his or her resources to cope (Lazarus & Folkman, 1984). According to this view, a woman's psychological experience of abortion will be mediated by her appraisals of the pregnancy and abortion, the significance it has for her life, her perceived ability to cope with those events, and the ways in which she copes with emotions subsequent to abortion (Major, Richards, Cooper, & Zubek, 1998).

Lazarus and Folkman's (1984, p. 141) classic definition states that coping includes "constantly changing cognitive and behavioral efforts to manage specific external and/or

internal demands that are appraised as taxing or exceeding the resources of a person". More recently, coping has been referred to as the ability to mobilize, modulate, manage and coordinate one's behaviour, emotions and attention under stress (Skinner & Zimmer-Gembeck, 2009). Coping in this sense refers to reactive behaviour, while proactive coping focuses on utilizing or developing general resources to facilitate personal growth (Schwarzer & Knoll, 2003). It involves actively aiming towards improvement of one's life and environment, even in the absence of a stressful event (Roesch et al., 2009). Schwarzer and Knoll (2009) further explain that proactive coping involves striving to maximize gains, trying to obtain additional resources and working towards growing resistance to stress to handle future crises in the best possible way. It is therefore clear that proactive coping integrates processes of personal quality of life management with those of self-regulatory goal attainment.

Bandura (2001) defines self-regulation as agency that enables people to play a part in their self-development, adaptation and self-renewal within changing contexts. Self-regulation entails both action control, the ability to regulate one's feelings and behaviour (Baumann, Kaschel, & Kuhl, 2005), and attention control, the ability to keep one's attention focused on a given goal in spite of distractors (Diehl, Semegon, & Schwarzer, 2006). This means that an individual with good self-regulation skills has the ability to not only alter own behaviour and responses effectively (Peterson & Seligman, 2004), but also to perform proactively and anticipatorily (Bandura, 2001) to minimize the impact of stressful events (Berger, 2011). In terms of an unwanted pregnancy and the decision to abort, a focus on coping as self-regulatory process could potentially contribute to understand why women have different experiences of an induced abortion as well as what role the facilitation of proactive coping skills may play in post-abortion adjustment and well-being.

However, no clear data is available, specifically for a South African context, on how women subjectively experience abortion and how these women cope with the abortion experience. It is not known therefore to what extent current models of coping with abortion are valid and which intervention approaches are applicable to the South African context. Furthermore, there is a lack of data on how coping with abortion specifically reflects self-regulatory processes, in other words the ability to steer one's behaviour towards goal accomplishment during this time of change, loss, stress and uncertainty. Information in this regard could contribute nationally and internationally to knowledge about how women cope with having an abortion. This research could provide health service providers in South Africa with a better understanding of women's experience of abortion and help direct pregnancy options, counselling and referrals for post-abortion care.

The aims of the study were therefore to (i) systematically explore and synthesize scientific evidence on how women experience and cope with induced abortion; and to (ii) determine to what extent their coping strategies reflect a sense of agency and self-regulation

Methodology

Research Design

A rapid review of current international and national literature on the experience of abortion and the ways of coping with the experience of abortion was conducted. A rapid review is an accelerated or streamlined systematic review (Ganann, Ciliska, & Thomas, 2010). A rapid review was selected as this was the first of three phases in a larger study and since it could be a useful precursor to new research (Petticrew & Roberts, 2006). The guidelines of the National Institute for Health and Clinical Excellence (NICE) (2012) for conducting a rapid review were used as a basic framework for this study.

Keyword search strategy

The North-West University (NWU) One Search portal was used in consultation with a librarian at the NWU to do the search. One Search is a simple search engine that provides a fast, accurate and comprehensive search of 262 electronic databases. The following keywords were used in combination with Boolean operators (AND, OR, NOT) to conduct the search:

In the abstract:

Cope OR Coping OR manag* OR adapt* OR adjust* OR handl* OR surviv* OR endure* OR control* OR “proactive coping” OR “reactive coping” OR “emotion-focused coping” OR “stress management” OR “problem-focused coping” OR experience* OR “living with”.

AND (in title):

Abortion* OR “Termination of pregnancy” OR “abortion*” OR “elective abortion*” OR “therapeutic abortion*” OR feticide* OR aborticide* OR “deliberate miscarriage*” OR “unplanned pregnanc*” OR “unwanted pregnanc*” OR “legal abortion*” OR abortifacient* OR “unintended pregnanc*” OR feticide* OR “induced miscarriage*” OR “medical abortion*” OR post-abortion* OR “abortion trauma” OR “post-abortion syndrome”.

AND (in abstract):

“young adult*” OR “emerging adult*” OR “college student*” OR “university student*” OR student* OR “18-35” OR “young women”.

All published English empirical studies, qualitative, quantitative, mixed- or multi-method in design, were included, with no limit on date of publication. These studies had to focus on coping with induced abortion due to an unwanted pregnancy among young women aged 18 and older. Review studies, unpublished studies, conference proceedings, studies in a language other than and without an abstract in English, were excluded.

Selection of studies to be included

The two researchers independently reviewed the titles of all initially selected studies (n=537, see figure 1).

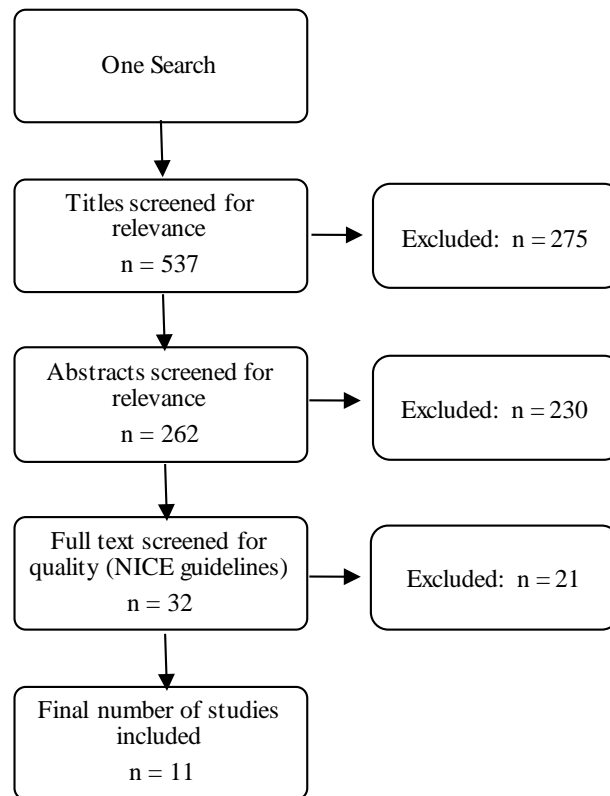


Figure 1: Search Flow Chart: Realization of Search Strategy

Non-relevant articles were excluded, after which the abstracts of those articles left (n=262) were assessed for a second round of relevance assessment. It was clear at this stage that the age criteria of 18 and older would be a problem as a large number of studies included participants from the age of 16 and some even from age 14 or 15. It was decided not to exclude these, but to be conscious of any age-related issues that might emerge, especially regarding developmental age. After this process and once consensus had been reached, the full text of the remaining studies (n=32) were retrieved and assessed to determine their

scientific quality. The quality assessment tools for both quantitative and qualitative studies (NICE, 2012) were used to critically appraise the quality of all the relevant articles. Based on this process, 11 studies were selected for final inclusion.

Data extraction from the final group of selected articles

The framework of the Evidence for Policy and Practice Information and Coordinating Centre (2007) for conducting systematic reviews was used to extract the data from the 11 selected studies (see Table 1). The framework is based on a standardized set of pre-determined criteria for each study with reference to (i) general descriptive information; (ii) research methodology; and (iii) results.

Data Analysis

A narrative synthesis (Popay et al., 2006) was conducted to synthesize the findings from the 11 final articles. This is a data analysis approach often used in rapid reviews to synthesize the findings from multiple studies. It relies primarily on the use of words to summarize and explain the findings of the synthesis. A narrative synthesis was chosen since it is a trustworthy approach that focuses on answering a wide range of questions, and not only those relating to the effectiveness of a particular intervention (Popay et al., 2006). The data were analysed according to the guidelines provided by Petticrew and Roberts (2006), namely: (i) organizing the description of the studies into logical categories, (ii) analysing the findings within each of the categories, and (iii) synthesizing the findings across all included studies. Although the studies included different methodological approaches, the focus was on the description and narrative interpretation of the results.

Ethics and trustworthiness

The Health Research Ethics Committee (HREC) of the NWU provided ethics approval for this research (ethics approval number NWU-00059-16-S1). A rapid review is rigorous

and systematic and adheres to the core principles of a traditional systematic review to avoid bias during any stage of the process (Schünemann & Moja, 2015). This research study was conducted in a professional manner to ensure its integrity and to avoid any misconduct.

The researcher adhered to a carefully planned research process by strictly following the NICE and EPPI guidelines. The research was conducted in a reflective way, while all results were recorded and documented according to the review protocol. During continuous reflection on the research process, care was taken to ensure that the research was both thorough and critical. Finally, trustworthiness and credibility were increased by adhering to the three guidelines proposed by Wager and Wiffen (2011, pp. 131-133), namely to avoid redundant publication, avoid plagiarism and to ensure transparency.

Results

Eleven studies published between 1973 and 2015 were identified as eligible for inclusion in this research paper (see Table 1 for data extraction). Of these, five used quantitative methods (Costa, Jessor, & Donovan, 1987; Curley & Johnston, 2013; Fingerer, 1973; Lundell et al., 2013; Taft & Watson, 2008), five used qualitative methods (Boulind & Edwards, 2008; Gray, 2015; Halldén, Christensson, & Olsson, 2009; Harden & Ogden, 1999; Monsour & Stewart, 1973) and one used a multi-method approach (Fergusson, Horwood, & Ridder, 2006). Boulind and Edwards (2008) were the only researchers who followed a single case study approach. Quantitative methods almost exclusively included questionnaires and standardized scales, while qualitative data were collected by means of in-depth interviews, with the exception of Gray (2015), who used an online semi-structured survey and open-ended questions.

The majority of the studies focused on the mental health sequelae of unplanned pregnancy and abortion with different focuses, namely general mental health (Fergusson et al, 2006; Harden & Ogden, 1999), general stress and depression (Curley & Johnston, 2013; Taft

& Watson, 2008), posttraumatic stress (Boulind & Edwards, 2008; Lundell et al, 2013), and sexual self-image (Monsour & Stewart, 1973). One study (Costa et al., 1987) specifically focused on how antecedents of abortion relate to participants' experience. Another study took a psychoanalytic perspective (Fingerer, 1973), while two studies (Gray, 2015; Halldén et al., 2009) focused on how young women give meaning to their abortion experience through narratives. Finally, only one of the studies were done in South Africa (Boulind & Edwards, 2008), four were done in the USA (Costa, Jessor, & Donovan, 1987; Fingerer, 1973; Gray, 2015; Monsour & Stewart, 1973), two in Sweden (Halldén et al., 2009; Lundell et al., 2009), one each in the UK (Harden & Ogden, 1999), Australia (Taft & Watson, 2008) and New Zealand (Fergusson et al., 2006), while one study was done in both Canada and the USA (Curley & Johnston, 2013).

Table 1: Data Extraction of the Eleven Eligible Studies.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
1	(Boulind & Edwards, 2008)	The assessment and treatment of post-abortion syndrome: A systematic case study from South Africa	To offer a clinical description of post-abortion syndrome (PAS) in a black Zimbabwean women.	Qualitative	1 Female, black, Zimbabwean, 22 years old.	Clinical case study: Intake interviews, session records, and the Beck Depression Inventory II (BDI-II) and Beck Anxiety Inventory (BAI).	Factors that contributed to vulnerability to PTSD included active suppression of the event and lack of social support. The woman experienced conflict about ending the pregnancy, self-criticism, guilt, hyperarousal, anxiety, detachment and depression secondary to PTSD. Abortion was experienced as painful due to isolation and lack of support. Experience of relief on the disclosure of the abortion.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
2	(Costa, Jessor, & Donovan, 1987)	Psychological correlates and antecedents of abortion: an exploratory study	To examine the relationship between young adult women's abortion experience and a variety of antecedent and subsequent personality, perceived environment, and behaviour variables.	Quantitative	Longitudinal study, final sample size 215 high school women, 99 college women. Phase one in adolescence, aged 16, 17 and 18 years. Phase two in young adulthood, average age of 22 years.	Questionnaire with scales/indexes developed to assess the personality, social and behavioural variables within the framework of problem-behaviour theory.	Premorbid factors influence experience: Personality. Women who have had an abortion tend to be more unconventional than those who have not had an abortion.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
3	(Curley & Johnston, 2013)	The characteristics and severity of psychological distress after abortion among university students	To identify the characteristics, severity and treatment preferences of university students who experiences psychological distress after abortion.	Quantitative	151 females, 89 of whom experienced abortion, 18 to 35 years	Brief Symptoms Inventory (BSI), Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), Impact of Event Scale (IES), Perinatal Grief Scale (PGS) and demographic and health questionnaire	All women who had abortions reported symptoms of PTSD and grief lasting an average of three years. Psychological distress after abortion (PAD) appeared multi-factorial, associated with the abortion, co-existing mental health problems and overall emotional health. Women made use of avoidance coping. Depression, anxiety and suicide were noted.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
4	(Fergusson et al., 2006)	Abortion in young women and subsequent mental health	To determine the extent to which abortion has harmful consequences for mental health.	Multi-method approach	1265 children born in Christ-church (NZ). Analysis based on the cohort of female participants for whom information on pregnancy history and mental health outcomes was available. Sample sizes used ranged between 506 and 520 depending on the timing of assessment, 15 to 25 years.	Interviews, Diagnostic Interview Schedule for Children (DISC) and Composite International Diagnostic Interview (CIDI).	In young women, exposure to abortion was associated with a detectable increase in the risk of concurrent and subsequent mental health problems. This included depression, anxiety, suicidal behaviours and substance use disorders.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
5	(Fingerer, 1973)	Psychological sequelae of abortion: anxiety and depression	To determine whether abortion has immediate negative psychological after-effects as predicted by psychoanalytic theory, but unconfirmed by research.	Quantitative	Group 1a: 324 women who came to the clinic for an abortion 14 to 44 years old. Group 1b: 177 abortion patients who returned completed tests. Group 2: 207 men and women who accompanied Group 1a to the clinic. Group 3: 21 male and 15 female postdoctoral students in psychology. Group 4: 43 females role playing.	State-Trait Anxiety Inventory-State (STAI-S), Affective Adjective Check List-Today (AACLT) and Measure of Depressive Symptomatology (SDS).	There is no immediate anxiety after abortion. The psychological after-effects of abortion seem to reside in psychoanalytic theory and social myths. Only minor psychological discomfort, mainly of depressive nature, may occur after the abortion. Social stigma contributes to socially learned responses to abortion. Abortion seems to result in immediate relief rather than anxiety and depression. Mild depression most likely due to the reactive situational adjustment.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
6	(Gray, 2015)	“It has been a long journey from first knowing”: Narratives of unplanned pregnancy	To identify themes in unplanned pregnancy narratives.	Qualitative	241 young women aged 18 to 24 years.	Online semi-structured survey with open-ended narrative question.	Narratives were effective in positively reappraising and making sense of the experience, especially in terms of autonomy and justification of the decisions made. Self-reflection on different outcomes. Women experienced ambivalence, guilt, depression, pain, helplessness and lack of social support. Most frequent stressors: physical, lack of control, emotional disturbances.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
7	(Halldén et al., 2009)	Early abortion as narrated by young Swedish women	To illuminate the meanings of having had an abortion among young Swedish women.	Qualitative	10 women aged 18–20 years after medical or surgical abortion in the sixth to twelfth week of pregnancy.	Narrative Interviews	<p>Multitude of complex meanings in young women’s lived experiences of abortion. Five themes:</p> <p>Protectiveness and feeling responsible towards the pregnancy.</p> <p>Thoughtful decision making, sensitivity to others’ approval.</p> <p>Imagining the loss of the child-to-be.</p> <p>Independent comprehensive understanding.</p> <p>Ambivalence: Both positive and negative feelings.</p> <p>Experience of pain and injustice.</p> <p>Experience of relief.</p>

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
8	(Harden & Ogden, 1999)	Young Women's experiences arranging and having abortions	Assess whether women's experiences in the UK are similar to those reported in the literature and whether the moral context reported previously still holds in the late 20th century.	Qualitative	54 young women aged between 16 and 24 years who had an abortion.	Interviews	Most abortion experiences were positive and at times even negative expectations were compensated for by supportive staff. However, some women experienced judgement and insensitivity from health professionals. Abortion brought relief and restored lack of control. Negative emotions such as shock, anxiety, guilt and anger were experienced. Women had the strong desire for things to go back to normal.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
9	(Lundell et al., 2013)	Posttraumatic stress among women after abortion: A Swedish multi-centre cohort study	To assess the prevalence of PTSD and PTSS before and at three and six months after abortion and to describe the characteristics of the women who developed PTSD or PTSS after the abortion.	Quantitative	1457 women who requested an abortion, 15 years to 35 years and older.	Screening Questionnaire-Posttraumatic Stress Disorder (SQ-PTSD) and Hospital Anxiety and Depression Scale (HADS)	Few women developed PTSD or PTSS after the abortion, and if so, it was due to trauma experienced unrelated to the abortion. However, women experienced guilt, sadness and ambivalence. They had concomitant symptoms of depression and anxiety. Painful feelings decreased.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
10	(Monsour & Stewart, 1973)	Abortion and sexual behaviour in college women	To assess the consequences of abortion as seen in changes in self-perception and self-image, alterations in sexual feelings and behaviour, and modification of attitudes towards childbearing and children.	Qualitative	20 single young college women 18 to 22 years old.	Interviews and demographic questionnaire	No appreciable psychological after-effects. Abortion brings relief from stress and resolves the crisis of unwanted pregnancy. No detrimental effects on personal attitudes in their self-perceptions relating to motherhood, childbearing, their bodies or attitudes towards children. Psychological growth results from the abortion. Stress experienced due to hospital staff's reaction towards them. Lack of social support.

Number of Study	Author(s) of Study	Title of Study	Aim	Methodological approach	Sample characteristics	Measurement	Essence of findings
11	(Taft & Watson, 2008)	Depression and termination of pregnancy (abortion) in a national cohort of young Australian women: the confounding effect of women's experience of violence)	To examine the associations with depression of women's experience of violence, pregnancy termination, births and socio-demographic characteristics among a population-based sample of young Australian women.	Quantitative	14 776 women aged 18–23 years in survey 1 and 9 683 women aged 22–27 years in survey 2.	Centre for Epidemiological Studies Depression Scale (CES-D). Included socio-demographic variables of interest to survey. Survey also included questions on reproductive events and three questions about violence.	Violence, especially partner violence, made a significantly greater contribution to women's depression compared with pregnancy termination or births. Premorbid factors influenced the abortion experience: Poverty/social disadvantages, partner-related violence. Doubt significant causal link between depression and women's experiences of abortion.

The Effect of Premorbid Factors on an Abortion Experience

From the 11 articles, only two referred to the role premorbid factors play in the abortion experience, namely Taft and Watson (2008) and Costa et al. (1987). Taft and Watson (2008) found both premorbid poverty / social disadvantages and partner violence to have an effect on a woman's experience of abortion. As this effect relates to post-abortion depression specifically, this finding is integrated later on when negative experiences related to abortion are discussed. Costa et al. (1987) indicated personality as a premorbid factor, but specifically in relation to the decision to abort or not. Women who decided to abort appeared to be more unconventional and less conforming to socially accepted norms and behaviour than those who did not. These authors measured unconventionality based on *personal beliefs* that included social criticism, sex role liberalism and political liberalism and *personal controls* that included intolerance of deviance, religiosity and moral attitude regarding abortion. Women who decided to abort were more socially critical and more liberal regarding sex roles and politics and less tolerant of deviance, less religious and had fewer moral objections to abortion. Therefore, the decision to have an abortion is related to a pre-existing pattern of unconventionality. Age-related issues did not emerge as a factor at all.

Stressors related to an Abortion.

Social stressors.

Five studies (Boulind & Edwards, 2008; Fingerer, 1973; Gray, 2015; Harden & Ogden, 1999; Monsour & Stewart, 1973) found social factors, more specifically social learning, stigma and lack of social support to be important stressors related to the abortion experience. Fingerer (1973) found that the minor post-abortion psychological discomfort that women experienced took root due to the socially learned responses to the abortion situation rather than as a result of the abortion itself. This socially learned responses refer specifically to the "motherhood myth", which refers to the idea that a woman's highest function is to be a 'good

mother'. Therefore, by having an abortion, the woman in question has not fulfilled her highest function. Not only do socially learned responses play a role in the abortion experience, but also the social reactions from the hospital staff. Both Monsour and Stewart (1973) and Harden and Ogden (1999) found participants to have experienced medical staff as judgemental and insensitive, which caused them to experience more stress. Furthermore, there may be a link between the abortion stigma and social support, since one of the participants in Gray's (2015) study reported that she kept her abortion a secret due to the fear of the social stigma attached to abortion. This implies that she probably also experienced a lack of social support, a further factor noted by Monsour and Stewart (1973), Gray (2015) and Boulind and Edwards (2008). The lack of support was attributable to secrecy, avoiding the abortion stigma, and experiencing rejection from unsupportive friends.

Ambivalence or Conflict.

Four studies (Bouland & Edwards, 2008; Gray, 2015; Halldén et al., 2009; Lundell et al., 2013) found ambivalence or conflict to be related to the abortion experience. Three of these (Bouland & Edwards, 2008; Gray, 2015; Lundell et al., 2013) report that women experienced ambivalence about the abortion decision. Halldén et al. (2009) in contrast, describe abortion as a complex event characterized by the experience of ambivalent positive and negative emotions.

Lack of autonomy and control.

Three studies (Curley & Johnston, 2013; Gray, 2015; Harden & Ogden, 1999) report specific stressors that all hint at a lack of autonomy or control over various aspects of the study participants' lives. Curley and Johnston (2013) emphasize the feeling of being overwhelmed by the unplanned pregnancy and the abortion as a main stressor, which subsequently developed into different mental health issues. Gray (2015) states that the most recurrent and dominant stressors that women experienced throughout the abortion involved

lack of control over one's body and inner self. Harden and Ogden (1999) also found the dominant stressor to be the lack of control and noted that the prolonged abortion procedure contributed to additional stress, together with the strong desire for things to return to normal.

Negative emotions experienced in relation to an Abortion.

Depression.

Six studies (Boulind & Edwards, 2008; Curley & Johnston, 2013; Fergusson et al., 2006; Fingerer, 1973; Gray, 2015; Taft & Watson, 2008) found deviation in mood, most specifically depression, to be associated with abortion. Fingerer (1973) found an occurrence of mild depression most likely due to the reactive situational adjustment in the form of desensitization or re-evaluation of learned beliefs regarding abortion. According to Boulind and Edwards (2008), depression developed when thoughts and feelings associated with the abortion were repressed. The depression was further worsened by feelings of guilt and other factors unrelated to the abortion. According to Gray (2015), women experienced a feeling of helplessness and depression.

Taft and Watson (2008) provide a slightly different explanation and indicate that abortion only has a peripheral association with depression. According to them, 30% of women between the ages of 22 and 27 years were likely to have depression after abortion, but they argue that both poverty and social disadvantages contribute to depression after abortion. Women who were married or living together were less likely to report depression than single or divorced women. Women with post-secondary qualifications, tertiary degrees and women with private health insurance were less likely to be depressed when compared to women with only secondary education and women with no private health insurance. In addition, women with clerical or trade jobs or with home duties were also more likely to be depressed than managerial or professional woman. However, and perhaps surprisingly, women living in rural areas were less likely to be depressed compared to women living in urban areas. An

additional factor, according to Taft and Watson (2008), is violence. Women who specifically experienced partner violence, were significantly more likely to experience depression after abortion. This is further enhanced when other adverse reproductive events (more frequent pregnancies, miscarriages and troubled reproductive history) had been encountered. According to Taft and Watson (2008), these factors, rather than their experience of the abortion itself, increase the possibility of experiencing depression.

Anxiety.

Seven studies (Boulind & Edwards, 2008; Curley & Johnston, 2013; Fergusson et al., 2006; Fingerer, 1973; Gray, 2015; Harden & Ogden, 1999; Lundell et al., 2013) report on the role anxiety plays in the experience of abortion. Fingerer (1973) reports that no immediate anxiety was observed after the abortion. However, Fergusson et al. (2006) found that women who had had abortions had much higher rates of anxiety disorders than women who had not had abortions. Gray (2015) reports anxiety based on women's fear that others would find out about the abortion, anxiety about future pregnancy and anxiety about dealing with the abortion on their own. Curley and Johnston (2013) measured state and trait anxiety among three groups of women, namely women who had an abortion and preferred psychological services; women who had an abortion and did not prefer psychological services; and a control group. They found that more than 50% of women who had had an abortion preferred psychological services, while the situational anxiety was also higher among this group. Boulind and Edwards (2008) made use of the Beck Anxiety Inventory in a case study and report panic, generalized anxiety and residual symptoms of anxiety three months later. Harden and Ogden (1999) found that women experienced anxiety in the form of isolation and disempowerment. Furthermore, Lundell et al. (2013) noted that although anxiety is naturally associated with abortion, only a minority of women developed posttraumatic stress disorder

(PTSD) or even posttraumatic stress symptoms (PTSS) after abortion. This was, however, due to trauma experiences unrelated to the abortion.

Physical and emotional pain.

Four studies (Boulind & Edwards, 2008; Curley & Johnston, 2013; Gray, 2015 Halldén et al., 2009) report on the experience of both physical and emotional pain, in all cases related to each other. Both Gray (2015) and Halldén et al. (2009) report that participants described the abortion procedure as both physically and emotionally painful, while Curley and Johnston (2013) report that physical pain may have led to anxiety. Halldén et al. (2009) specifically report that the emotional pain was associated with observing the foetus during the abortion and having to take away their child that they could have had. Boulind and Edwards (2008) state that the participant in their study expressed pain due to her isolation and lack of support throughout the whole abortion process.

Guilt.

Four studies (Boulind & Edwards, 2008; Gray, 2015, Harden & Ogden, 1999; Lundell et al., 2013) report guilt as part of the abortion experience. Lundell et al. (2013) found that only a small group of women experienced guilt and that it commonly arose among women who had feelings of ambivalence about the abortion. The women in Gray's study (2015) constantly thought about the abortion due to their guilt feelings about the abortion decision. They reported feeling like a bad person, felt guilt about having unprotected irresponsible sex and regarding future pregnancies and motherhood. Harden and Ogden (1999) also found participants to report feelings of guilt about falling pregnant and feeling irresponsible. Furthermore, the participant in the case study of Boulind and Edwards (2008) mentioned that she felt guilty about the abortion due to shame, fear of disappointment and feeling like a 'bad' person.

Coping with an Abortion.

Self-Reflection: Trying to Make Sense of the Experience.

Three studies (Bouland & Edwards, 2008; Gray, 2015; Halldén et al., 2009), describe how women self-reflected during and after an abortion and how it contributed to their efforts to cope with the associated stressors and mental symptoms. Gray (2015) found that women reflected on the decision making process by justifying the decision to abort, while Bouland and Edwards (2008) note that the participant in their case study made use of self-criticism as she felt disappointed with herself for rushing into the decision to have an abortion without thorough consideration.

Halldén et al. (2009) found women to self-reflect in five different ways. First, women self-reflect for protection of and out of a sense of responsibility towards the pregnancy. They were surprised and experienced disbelief about becoming pregnant and used self-reflection to see themselves as someone else who is experiencing the reality of the abortion. Some women also chose a healthier life prior to the abortion, indicating that self-reflection may be used as a form of taking responsibility even before the decision is made to continue with the pregnancy or not.

Second, self-reflection was used to facilitate thoughtful decision making. In this case, the decision was considered as being both selfish and unselfish, since having the abortion meant being selfish about their wishes for their own lives and being unselfish about the consequences for the child. Third, self-reflection was used to deal with sensitivity to the approval of others. The participants considered support as very important, especially the approval of their parents, in particular their mothers, and then partners and professionals. Some participants experienced rejection due to the disapproval of others. Fourth, they reflected by imagining the loss of the child-to-be. Loss was imagined as a physical void,

feelings of being the aborted child's mother and visualizing the partner as the father. In addition, they self-reflected on the worry of not being able to have children later in life. Gray (2015) also noted self-reflection as imagining how everything could have been different. Finally, Halldén et al. (2009) found that self-reflection was used to obtain an independent comprehensive understanding of the abortion, including the unimaginable pregnancy, an impression of the child-to-be and disquiets about future fertility.

Avoidance Coping.

In comparison to self-reflection as coping, only three studies (Boulind & Edwards, 2008; Curley & Johnson, 2013; Halldén et al., 2009) clearly found evidence of avoidance coping. Curley and Johnston (2013) report that the primary means of coping involved avoiding the abortion experience. They further explain that some of the participants were incapable of coping with the overwhelming thoughts and feelings of the abortion and therefore preferred psychological services. In the case study of Boulind and Edwards (2008) the participant mentioned that she felt guilty about the abortion and coped by repressing her thoughts on the abortion and avoiding talking about the experience. Finally, Halldén et al. (2009) found that the pain was eased by avoiding thinking of the child that they could have had, perceiving the foetus as a nonhuman being, seeing the abortion as a miscarriage and assigning the responsibility of the abortion decision to the staff that performed the abortion.

Positive experiences.

Six studies (Boulind & Edwards, 2008; Fingerer, 1973; Gray, 2015; Harden & Ogden, 1999; Halldén et al., 2009; Monsour & Stewart, 1973) report positive experiences as a result of the abortion. These were primarily experienced in the form of relief because the abortion resolved the crisis of the unwanted pregnancy (Halldén et al., 2009; Monsour & Stewart, 1973); because they could continue living normal lives again (Halldén et al., 2009; Harden & Ogden, 1999); because they could disclose their abortion experience (Boulind & Edwards,

2008; Halldén et al., 2009); because they did not experience the physical symptoms of the pregnancy anymore; and because the abortion experience differed from their expectations (Harden & Ogden, 1999). The only other positive experience, namely a sense of autonomy regarding the decision to abort, was reported by one study only (Gray, 2015).

Discussion

From the rapid review it is evident that the experience of abortion differs among women and various factors play a role in their experience of the unwanted pregnancy and abortion. Five broad themes were identified, namely premorbid factors, stressors, negative emotions, coping strategies and positive experiences. The themes were not exclusive. For example, premorbid factors like social disadvantage and partner violence and stressors related to the abortion, were found to influence the experience of abortion, while coping strategies were most often based on the nature of negative emotions experienced. In a general sense, the findings of the review are not surprising as it is primarily supported by other studies within the review and by literature in general, while not many contradictory findings were noted.

The first noteworthy implication of the study is that certain premorbid factors may be important in understanding the experience of and coping with abortion. In this review, personality was indicated to influence the decision to abort or not (Costa et al., 1987). As this study was done three decades ago, and as attitudes about abortion have changed significantly since then, the finding should be interpreted cautiously. The most relevant question is perhaps to what extent having a more positive attitude towards abortion makes the decision and coping process easier? Also, even though a positive attitude towards abortion might be a protective factor, the experience of abortion is often negatively influenced by premorbid socio-economic challenges and partner violence (Taft & Watson, 2008). This is especially important in the South African context, as a lack of financial resources and social support (Ndwambi & Govender, 2015; Sullivan et al., 2017; Torriente et al., 2016) are often indicated

as the primary reasons for having an abortion. In addition, it seems as if a history of partner violence is often associated with a higher rate of unintended pregnancies and abortion requests (Pallitto et al., 2012; Tingl f, H gberg, Lundell & Svanberg, 2015), and is related to more stress, anxiety and depression (Tingl f et al., 2015). The role of premorbid socio-economic factors should therefore be taken into account in abortion counselling, especially in a developing country like South Africa.

Second, it is clear that the abortion process is associated with a number of stressors that challenge young women on different levels of their lives. Perceived lack of support during an unwanted pregnancy and abortion is not a surprise and is confirmed by researchers like Sa nchez-Siancas, Rodr guez-Medina, Piscoya and Bernabe-Ortiz (2018). Stigma, however, is a more complex issue and may overlap with other factors, like perceived lack of support. A systematic review about abortion stigma (Hanschmidt, Linde, Hillbert, Riedel-Heller, & Kersting, 2016) concluded that women who had abortions experience fear of social judgement, self-judgement and the need to keep their abortion a secret. Mookamedi et al. (2015) report based on a South African study that women felt stigmatized after abortion and perceived themselves as “murderers” due to their religious contexts. It is therefore no surprise that stigma often manifests as feelings of guilt, shame, anxiety, secrecy or unease about other people’s beliefs about abortion (Shellenberg & Tsui, 2012; Sullivan et al., 2017). The question therefore emerges as to the extent to which the guilt and anxiety that women experience is due to the abortion itself or due to contextual factors such as stigma. Experiencing ambivalence and conflict and a lack of autonomy is expected in any adverse event. The fact that the decision to abort is preceded by an unwanted (or untimely) pregnancy further complicates matters as it challenges one’s goals, identity, or even values. Although the ambivalence and lack of autonomy may be related to perceived stigma and lack of social support, none of the studies explicitly interpreted or reported it as such.

Some studies report that the stressors related to abortion often result in emotions like negative affect / emotional pain, anxiety and guilt and in some cases develop into psychological disorders like depression and even PTSD. It is surprising to some extent that none of the studies explicitly report on perinatal grief as such, although it is implied in most cases where depression or emotional pain were reported. Some contradictions or inconsistencies were also noted, for example, whereas depression was reported in a number of studies, Taft and Watson (2008) report that there is no causal link between women's abortion experiences and depression. This contradiction is also noted in literature not included in this review, for example Boersma, Van den Berg, Van Lunsen and Laan (2014), Foster, Steinberg, Roberts, and Neuhaus (2015) and Gomez (2018). The same is noted regarding anxiety. Even though seven studies in the review report anxiety symptoms, this is not necessarily supported by literature not included in the review (compare Foster et al., 2015). The experience of pain and guilt is subjective and physically and emotionally intertwined and largely supported by the literature (compare Mookamedi et al., 2015; Sullivan et al., 2017). However, there is not enough evidence on whether and how emotional pain and guilt are separate to either feelings of depression or anxiety. It is probably best to regard it as part of the subjective experience of both. Therefore, even though clear signs of distress are reported, the severity thereof, the extent to which it puts women at risk of developing psychological disorders and which women would be at risk therefore still needs more clarity.

The review reveals two broad coping efforts, namely avoidance and self-reflection. According to Dykes, Slade and Haywood (2011), avoidance coping is used when the memories about the abortion is suppressed by actively trying to forget and avoiding thinking about it, while self-reflection is used when the decision to abort and thoughts and fears regarding future fertility are rationalized. Avoidance is usually perceived to be a less adaptive

type of emotion-focused coping in comparison to the recognition, processing and expression of emotion (De Ridder & Kuijer, 2006). The functionality of coping efforts should however always be seen in context given the stigma associated with abortion, avoidance may be temporarily functional. It could also be that avoidance leads women to self-reflect, which in turn may lead to avoidance if the experience of stigma and rejection is emphasized through self-reflection. However, this should be explored in future research. The lack of problem-solving coping is not adequately explained in any of the review studies, but may link to feelings of depression and anxiety and the lack of social support. It may in addition be explained by the general belief that problem-solving coping fits controllable situations and emotion-focused coping fits uncontrollable situations (Benyamini, 2009). Therefore, future research should explore the possibility that the women in the review studies did not apply problem-solving coping as they did not perceive their situation as controllable, and did not apply more adaptive emotion-focused coping because of the stigma and secrecy of the situation.

Finally, although not strong, some of evidence suggests the presence of positive experiences in the form of relief and a sense of autonomy despite the challenges young women face. Quinley, Ratcliffe and Schreiber (2014) report that abortion primarily provides relief to women who present for abortion. Not only did the participants in a study conducted by Kero, Högberg and Lalos (2004) report relief after the abortion, but abortion is also described as a positive experience with regard to mental growth and maturity. Although not much evidence emerged from the review, both a sense of relief and autonomy may represent a form of self-protection against resource loss from a conservation of resources perspective (Frydenberg, 2014). It may even facilitate a broadening of resources from the “broaden and build” theory in positive psychology (Fredrickson, 2013). According to Fredrickson, even

fleeting micro-moments of positive emotions are able to reshape people by setting them on trajectories of growth and building their enduring resources.

Limitations.

Some limitations should be considered before reaching a conclusion:

Relatively few studies (n=11) were included and caution should therefore be exercised when drawing conclusions about the experience of abortion in general. A possible limitation is that some older studies were included, and their findings should be interpreted keeping in mind that the social context has changed considerably. For example, both Monsour and Stewart (1973) and Harden and Ogden (1999) found that participants experienced medical staff as judgemental and insensitive, which caused them to experience more stress. It is possible that changing attitudes towards abortion and health care may reflect in the behaviour of medical staff today. Furthermore, it is possible, despite a thorough search strategy, that certain studies meeting the inclusion criteria were overlooked.

The studies were quite heterogeneous in methodological approach and quality, specifically with respect to how the experience of abortion was evaluated, and with respect to the cultural contexts in which they were conducted. It would therefore be impossible to generalize the findings to a South African context.

In addition, studies were generally not well controlled for the influence of external factors on the abortion experience. Only some aspects related to personality and social background were indicated. However, there may be more external factors that we are not aware of. Lastly, almost nothing emerged from the selected articles regarding coping as a self-regulatory process. As such, no specific conclusions can be made. However, it also highlights the lack of data in this regard and points to a gap in research that should be addressed.

Conclusion and future directions

The aim of the study was to systematically explore and synthesize scientific evidence regarding how women experience and cope with abortion. A rapid review was done to synthesize the findings of 11 studies complying with the inclusion criteria. As the study was exploratory in nature, and as the relatively small selection of articles were quite heterogeneous in methodology and cultural focus, caution was taken not to make any specific conclusions, but only to highlight a few general trends.

It was clear from the review that abortion is a complex emotional event that should be understood within the context of each individual rather than to generalize. It can be concluded that an unwanted pregnancy and abortion is intertwined and that the experience of abortion is not merely a simple experience in the life of a woman with an unwanted pregnancy. Each woman is uniquely acquainted with her abortion decision, experience and aftermath, mainly because the experience and coping efforts are greatly influenced by each women's context (including culture) and pre-abortion mental health. Although not much information was found for women in a South African context, it is clear that socio-economic disadvantages and premorbid relationships are important factors that should be better understood and managed in a developing country such as South Africa. Not only does the abortion context differ, but the perceived abortion stigma also stands apart for each woman's unique narrative. One can also question whether women experience a lack of support due to stigma or due to them isolating themselves as part of the abortion process? Psychological growth after having an abortion is therefore a possibility, but not a given, and will inevitably be affected by the unique abortion context of the individual.

In the light of the aforementioned, further research should be done to specifically explore:

- how premorbid socio-economic factors could be integrated in abortion counselling;

- the severity and extent to which distress put women at risk of developing psychological disorders post-abortion;
- the extent to which guilt and anxiety are more directly related to the abortion or perceived stigma / rejection by others;
- the nature and dynamics of coping styles and strategies associated with abortion – more specifically, the extent to which stigma, avoidance and self-reflection are related, and if and why problem-solving coping is generally lacking among women during the abortion process;
- factors that facilitate psychological growth in women after abortion, especially in the long run; and
- how women in South Africa experience and cope with abortion and how this compares with research findings from elsewhere around the world.

References

- American College of Pediatricians. (2018). Induced abortion: Risks that may impact adolescents, young adults, and their children. *Issues in Law and Medicine*, 33(1), 85-112.
- Bandura, A. (2001). Social Cognitive Theory: An agentic perspective. *Annual Review of Psychology*, 52, 1-26.
- Baumann, N., Kaschel, R., & Kuhl, J. (2005). Striving for unwanted goals: Stress-dependent discrepancies between explicit and implicit achievement motives reduce subjective well-being and increase psychosomatic symptoms. *Journal of Personality and Social Psychology*, 89, 781-799.
- Benyamini, Y. (2009). Stress and coping with women's health issues. A review from a self-regulation perspective. *European Psychologist*, 14(1), 63-71.
- Berger, A. (2011). *Self-regulation: Brain, cognition and development*. Washington DC: American Psychological Association.
- Bhekisisa Mail and Guardian Centre for Health Journalism. (2018, June 18). *Sexual and Reproductive Justice Coalition*. Retrieved from Abortion in South Africa: http://srjc.org.za/wp-content/uploads/2018/06/i8jNT5fVReGoh4Uray3r_Bhekisisa_SafeAbortion_final_2018.pdf
- Billings, A. G., & Moos, R. H. (1981). The role of coping responses and social resources in attenuating the impact of stressful life events. *Journal of Behavioral Medicine*, 4, 139-157.

- Boersma, A. A., Van den Berg, D., Van Lunsen, R. H., & Laan, E. T. (2014). Induced abortion is not associated with a higher likelihood of depression in Curaçao women. *The European Journal of Contraception and Reproductive Health Care, 19*, 359-367.
- Boulind, M., & Edwards, D. (2008). The assessment and treatment of post-abortion syndrome: A systematic case study from South Africa. *Journal of Psychology in Africa, 18*(4), 539-548.
- Charles, V. E., Polis, C. B., Shridhara, S. K., & Blum, R. W. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception, 78*(6), 436-450.
- Costa, F., Jessor, R., & Donovan, J. E. (1987). Psychosocial correlates and antecedents of abortion: An exploratory study. *Population and Environment, 9*(1), 3-22.
- Curley, M., & Johnston, C. (2013). The characteristics and severity of psychological distress after abortion among university students. *Journal of Behavioral Health Services and Research, 40*(3), 279.
- De Ridder, T. D., & Kuijer, R. G. (2006). Managing immediate needs in the pursuit of health goals: The role of coping in self-regulation. In D. De Ridder, & J. De Wit, *Self-regulation in health behavior* (pp. 147-168). Chichester: John Wiley.
- Diehl, M., Semegon, A. B., & Schwarzer, R. (2006). Assessing attention control in goal pursuit: A component of dispositional self-regulation. *Journal of Personality Assessment, 86*, 306-317.

- Dykes, K., Slade, P., & Haywood, A. (2011). Long term follow-up of emotional experiences after termination of pregnancy: women's views at menopause. *Journal of Reproductive and Infant Psychology, 29*(1), 93-112.
- Evidence for Policy and Practice Information and Co-ordinating Centre. (2007). *EPPI-Centre methods for conducting systematic reviews*. London: Social Science Research Unit, Institute of Education, University of London.
- Fergusson, D. M., Horwood, L., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47*(1), 16-24.
- Fingerer, M. E. (1973). Psychological sequelae of abortion: Anxiety and depression. *Journal of Community Psychology, 1*(2), 221-225.
- Foster, D. G., Steinberg, J. R., Roberts, S. C., & Neuhaus, J. (2015). A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychological Medicine, 45*(10), 2073-2082.
- Fredrickson, B.L. (2013).. Updated thinking on positivity ratios. *American Psychologist, 68*(9), 814-822.
- Frydenberg, E. (2014). Coping research: Historical background, links with emotion, and new research directions on adaptive processes. *Australian Journal of Psychology, 66*, 82-92.
- Ganann, R., Ciliska, D., & Thomas, H. (2010). Expediting systematic reviews: methods and implications of rapid reviews. *Implementation Science, 5*(5). doi: 10.1186/1748-5908-5-56

- Gomez, A. M. (2018). Abortion and subsequent depressive symptoms: an analysis of the National Longitudinal Study of Adolescent Health. *Psychological Medicine, 48*(2), 294-304.
- Gray, J. B. (2015). "It has been a long journey from first knowing": Narratives of unplanned pregnancy. *Journal of Health Communication, 20*(6), 736-742.
- Halldén, B., Christensson, K., & Olsson, P. (2009). Early abortion as narrated by young Swedish women. *Scandinavian Journal of Caring Sciences, 23*(2), 243-250.
- Hanschmidt, F., Linde, K., Hillbert, A., Riedel-Heller, S. G., & Kersting, A. (2016). Abortion Stigma: A Systematic Review. *Perspectives on Sexual and Reproductive Health, 48*(4), 169-177.
- Harden, A., & Ogden, J. (1999). Young women's experience of arranging and having abortions. *Sociology of Health and Illness, 21*(4), 426.
- Kero, A., Högberg, U., & Lalos, A. (2004). Wellbeing and mental growth - long-term effects of legal abortion. *Social Science and Medicine, 58*(12), 2559-2569.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Lundell, I. W., Öhman, S. G., Frans, Ö., Helström, L., Högberg, U., Nyberg, S., Svanberg, A. S. (2013). Posttraumatic stress among women after induced abortion: a Swedish multi-centre cohort study. *BMC Women's Health, 13*(1), 1-21.
- Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and Mental Health. *American Psychologist, 64*(9), 863-890.

- Major, B., Richards, C., Cooper, L. M., & Zubek, J. (1998). Personal Resilience, Cognitive Appraisals, and Coping: An Integrative Model of Adjustment to Abortion. *Journal of Personality and Social Psychology*, 74(3), 746.
- Major, B., Richards, C., Cooper, M. L., Cozzarelli, C., & Zubek, J. (1998). Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. *Journal of Personality and Social Psychology*, 74(3), 735-752.
- Mojapelo-Batka, E. M., & Schoeman, J. B. (2003). Voluntary termination of pregnancy: Moral concerns and emotional experiences among black South African adolescents. *South African Journal of Psychology*, 33(3), 144-153.
- Monsour, K. J., & Stewart, B. (1973). Abortion and sexual behaviour in college women. *American Journal of Orthopsychiatry*, 43(5), 804-814.
- Mookamedi, R. E., Mogotlane, S. M., & Roos, J. H. (2015, November). The experience of women who undergo termination of pregnancy in Mpumalanga Province, South Africa. *Africa Journal of Nursing and Midwifery*, 17, 146-161.
- National Collaborating Centre for Mental Health (NCCMH). (2011, December). Induced Abortion and Mental Health: a Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors. *Academy of Medical Royal Colleges*. Retrieved from Academy of Medical Royal Colleges: http://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf
- National Institute for Health and Clinical Excellence (NICE). (2012). *Methods for the development of NICE public health guidance*. Retrieved from National Institute for Health and Clinical Excellence: <http://www.nice.org.uk/about>

- Ndwambi, A., & Govender, I. (2015). Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal South Africa. *Southern African Journal of Infectious Diseases*, 30(4), 129-133.
- Pallitto, C. C., García-Moreno, C., Jansen, H. A., Heise, L., Ellsberg, M., & Watts, C. (2012). Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence. *International Journal of Gynecology and Obstetrics*, 120(1), 3-9.
- Peterson, C., & Seligman, M. E. (2004). Self-Regulation. In C. Peterson, & M. E. Seligman, *Character Strengths and Virtues. A handbook and classification* (pp. 510-513). Oxford: Oxford University Press.
- Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences: a practical guide*. Oxford: Blackwell.
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme*. Lancaster University.
- Quinley, K. E., Ratcliffe, S. J., & Schreiber, C. A. (2014). Psychological coping in the immediate post-abortion period. *Journal of Women's Health*, 23(1).
- Robinson, G. E., Stotland, N. L., Russo, N. F., Lang, J. A., & Occhiogrosso, M. (2009). Is there an "abortion trauma syndrome"? Critiquing the evidence. *Harvard Review of Psychiatry*, 17(4), 268-290.

- Roesch, S. C., Aldridge, A. A., Huff, T. L., Langner, K., Villodas, F., & Brandshaw, K. (2009). On the dimensionality of the Proactive Coping Inventory: 7, 5, 3 factors? *Anxiety, Stress & Coping, 22*, 327-339.
- Sa´nchez-Siancas, L. E., Rodrı´guez-Medina, A., Piscoya, A., & Bernabe-Ortiz, A. (2018). Association between perceived social support and induced abortion: A study in maternal health centers in Lima, Peru. *PLOS ONE, 13*(4), 1-11.
- Schünemann, H. J., & Moja, L. (2015). Reviews: Rapid! Rapid! Rapid! ...and systematic. *Systematic Reviews, 4*(4).
- Schwarzer, R., & Knoll, N. (2003). Positive Coping: Mastering Demands and Searching for Meaning. In S. J. Lopez, & C. R. Snyder, *Handbook of Positive Psychological Assessment*. Washington, DC: American Psychological Association.
- Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among patients in the USA: An exploration by race and Hispanic ethnicity. *International journal of Gynecology and Obstetrics, 118*(2), 152-159.
- Skinner, E. A., & Zimmer-Gembeck, M. J. (2009). Challenges to the developmental study of coping. In E. A. Skinner, & M. J. Zimmer-Gembeck, *Coping and the development of regulation. New directions for Child and Adolescent Development* (pp. 5-17). San Francisco: Jossey-Bass.
- Subramaney, U., Wyatt, G. E., Williams, J. K., Zang, M., Liu, H., & Chin, D. (2015). Depressive and post-traumatic stress symptoms following termination of pregnancy in South African women: A longitudinal study measuring the effects of chronic burden, crisis support and resilience. *The South African Medical Journal, 105*(11), 934-938.

- Suffla, S. (1997). Experiences of induced abortion among a group of South African women. *South African Journal of Psychology, 27*, 214-222.
- Sullivan, M. E., Harrison, A., Harries, J., Sicwebu, N., Rosen, R. K., & Galarraga, O. (2017). Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study. *Health Care for Women International*.
doi:10.1080/07399332.2017.1400034
- Taft, A. J., & Watson, L. F. (2008). Depression and termination of pregnancy (induced abortion) in a national cohort of young Australian women: The confounding effect of women's experience of violence. *BMC Public Health, 8*(1), 75.
- Templeton, A., & Grimes, D. (2011). Clinical practice. A request for abortion. *The New England Journal of Medicine, 2198-2204*.
- Thobejane, R. K. (2001). An investigation into the emotional reactions of black adolescent girls a week following an induced elective termination of pregnancy. *Medical University of Southern Africa, Pretoria*.
- Tingl f, S., H gberg, U., Lundell, I. W., & Svanberg, A. S. (2015). Exposure to violence among women with unwanted pregnancies and the association with post-traumatic stress disorder, symptoms of anxiety and depression. *Sexual and Reproductive Healthcare, 6*(2), 50-53.
- Torriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, South Africa. *Africa Journal of Nursing and Midwifery, 119-131*.

Wager, E., & Wiffen, P. (2011). Ethical issues in preparing and publishing systematic reviews. *Journal of Evidence-Based Medicine*, 4, 130-134.

World Health Organization. (2008, November 5). *Managing incomplete abortion. Education material for teachers of midwifery; midwifery educational modules*. Retrieved from World Health Organization:
http://whqlibdoc.who.int/publications/2008/9789241546669_3_eng.pdf

CHAPTER 3: MANUSCRIPT 2**The experience and coping strategies of a group of South African women who had an induced abortion**

R. Lyon¹, K.F.H. Botha¹ & L.D. Preston²

1 School for Psychosocial Health, North-West University: Potchefstroom Campus

2 School for Psycho-Social Education, North-West University: Potchefstroom Campus

R. Lyon *

3078 Fish Eagle Ave, Parys Golf & Country Estate

Parys

9585

roche.lyon@gmail.com

*To whom correspondence should be addressed

Running head: EXPERIENCE AND COPING STRATEGIES OF INDUCED ABORTION

Abstract

The aim of this article was to explore how a sample of young adult South African women who had undergone an induced abortion perceived the relationship between different aspects of their experience and coping with the event. An availability convenience sample of 37 participants took part in the study. Interactive Qualitative Analysis (IQA) was used as a method to create a conceptual model of participants' perceived experience and coping with an induced abortion. The model indicated that an unwanted pregnancy and abortion caused a perceived discrepancy between where participants wanted to be regarding important life goals and where they were at the time. The women primarily coped through avoidance in an effort to protect themselves from potential rejection and judgement while some also made use of meaning-focused coping. However, these efforts still fed back into the difficulties they encountered without any clear long-term positive outcomes. Implications and recommendations for further research are provided.

Keywords

Coping, induced abortion, termination of pregnancy, self-regulation, agency, Interactive Qualitative Analysis,

The experience and coping strategies of a group of South African women who had an induced abortion

Besides spontaneous abortion or miscarriage, abortion can be divided into two categories, namely therapeutic abortion, which refers to an abortion to prevent damage to the mother's health, and non-therapeutic or elective abortion, also known as induced abortion or abortion upon request (UnitedHealthcare, 2017). Induced abortion is therefore a medically induced miscarriage using pharmacological means and/or surgical procedures (Torriente, Joubert, & Steinberg, 2016). In this paper, "abortion" will further refer to legal induced abortion. Abortion is one of the most commonly found gynaecological procedures performed around the world (Kumar, Hessini, & Mitchell, 2009). In 2012 fifty per cent of the 84.9 million worldwide unintended pregnancies resulted in abortion. One million of these unintended pregnancies occurred in Southern Africa, of which 22 per cent ended in abortion (Sedgh, Singh, & Hussain, 2014).

South Africa is one of the few countries in the Southern African region to have legalized induced abortion (Birdsey, Crankshaw, Mould, & Ramklass, 2016). Due to South Africa's progressive abortion law (Birdsey et al., 2016), many abortions take place in South Africa every day. Mid-year estimates for abortions in South Africa have increased by 26 455 from June 1997 to May 1998, by 87 035 from June 2004 to May 2005 and by 89 126 from June 2014 to May 2015 (Cooper et al., 2016). In 2017, 73 072 documented abortions were performed at South Africa's legal state health facilities (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018). Ndwambi and Govender (2015) further report that repeat abortions in South Africa are higher than in most developed countries. In South Africa access to contraception is free at public health care facilities (Lince-Deroche et al., 2016), however less than 60% of sexually active women use a modern contraception method like sterilization, contraceptive medication commonly referred to as 'the pill', Intra Uterine Devices (IUD's),

injections, implants, male and female condoms or emergency contraception (National Department of Health South Africa, 2017).

According to national and provincial health departments, South Africa currently has 246 facilities that offer legal abortion (Bhekisisa, 2017). These public sector facilities provide both medical and surgical abortions, and although the methods available vary by facility and gestational age, the most frequently used during the first trimester is referred to as Manual Vacuum Aspiration (MVA) (Lince-Deroche et al., 2017). The implementation of medical abortions is aimed at addressing the barriers to safe abortion access in South Africa due to the limited number of providers of surgical abortions (Cooper et al., 2005; Kawonga et al., 2008). For example, the abortion service provider at the Reproductive Health Clinic of the Potchefstroom Hospital in the North-West Province is the only legal provider in this small-sized city (S. Seobi, personal communication, July 27, 2018). At this clinic, patients primarily receive medical abortions, but these are often accompanied by MVA to ensure that the abortion is successful (S. Seobi, personal communication, July 27, 2018). This abortion service is managed by a single trained sister who attends daily to a vast number of abortion patients: 543 abortions from January 2017 to December 2017 and 249 abortions from January 2018 to June 2018, all within the first 12 weeks of pregnancy. The majority of these patients do not use any contraceptives (S. Seobi, personal communication, July 27, 2018). When considering the number of legal facilities offering abortion, the racial and cultural diversity of South Africa, and the different abortion methods, one may expect women's experiences of and ways to cope with abortion to vary significantly. A rapid review (Lyon & Botha, 2018) confirmed this and indicated that factors such as stigma, lack of social support, poverty, premorbid partner violence, ambivalence and a lack of autonomy all play a role in the experience of and coping with abortion. This is also supported by Charles, Polis, Shridhara and Blum (2008); Hanschmidt, Linde, Hillbert, Riedel-Heller and Kersting (2016); Harries,

Cooper, Strebel and Colvin (2014); Kimport, Foster and Weitz (2011); and Major et al. (2000; 2009), who all found that women's abortion experiences and coping are affected by complex factors related to their individual characteristics, the characteristics of the pregnancy and their sociocultural environments. Major, Richards, Cooper, Cozzarelli and Zubek (1998) further explain that the experience of induced abortion is mediated by the woman's appraisal of both the pregnancy and the induced abortion, together with her perceived ability to cope and the ways in which she copes.

Coping is defined as "the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful" (Folkman & Moskowitz, 2004, p.745). Coping is perceived as self-regulatory (Aldwin, Skinner, Zimmer-Gembeck, & Taylor, 2011) as it entails the process of modulating and readjusting one's emotions, moods, thoughts, physiological state and actions to challenging or stressful contexts (such as abortion) to achieve an anticipated position or to move away from undesired conditions (McClelland & Cameron, 2012; Carver & Scheier, 1998; 2016; 2017). Moreover, self-regulation skills reveal how individuals anticipate challenging contexts and enable avoidance or minimization of these challenging contexts (Berger, 2011). This anticipatory ability clearly links to the concept of proactive coping (Aspinwall & Taylor, 1997), defined as coping with anticipated future stress. It involves an individual's efforts to prepare for challenging or stressful events that pose a threat to one's goals and general well-being as well as preventing detrimental outcomes (Aspinwall & Taylor, 1997). Proactive coping is also known as preventative coping since it is focused on building up resources that facilitate goal achievement and self-realization to prevent a detrimental outcome (Schwartz & Taubert, 2002; Aspinwall & Taylor, 1997). A central principle in proactive coping and self-regulation is that of agency, defined by Little, Hawley, Henrich and Marsland (2002) as volitional, goal-

directed behaviour that allows the individual, according to Bandura (2018), to make things happen by means of his/her own (“self”) actions.

The notion of agency is extremely important as it could give researchers the opportunity to understand coping with abortion as more than merely ‘survival’, but as a key aspect of psychological growth, even from the perspective of perceived adversity within a stigmatized context. However, as clearly indicated in the rapid review by Lyon and Botha (2018), not only is there a general lack of research on coping with abortion from a self-regulatory perspective, but also a lack of research on how South African women in particular cope with abortion given their social context. For a better understanding of the dynamic relationship between the experience of abortion, coping efforts and the extent to which these reflect or indicate a lack of self-regulation and agency, one needs the insider’s perspective of young South African women going through an abortion themselves.

Therefore, understanding abortion from a self-regulatory perspective means identifying the elements of experiencing the abortion, coping with the abortion, and the self-regulatory components of the coping efforts; as well as how the cause-effect relationship between these elements are perceived. Understanding the perceived cause-effect relationship can help researchers learn from women’s experience of abortion as a sequential, unfolding process and the extent to which it reflects self-regulation and a sense of agency. This self-regulatory perspective on coping with abortion may provide new insight as to how women in South Africa experience and cope with legal abortions, since self-regulation is a contextualized ability that frequently changes across different contexts (Cleary, Callan, & Zimmerman, 2012).

This study therefore aimed to explore how a sample of young adult South African women who had undergone an induced abortion perceive the relationship between different aspects of their experience and coping, and to develop a conceptual model based on that.

Methodology

Research Design

Interactive Qualitative Analysis (IQA) (Northcutt & McCoy, 2004) is a structured approach to qualitative research that aims to reduce traditional power relations and biases found in qualitative research. The goal of IQA is to determine how participants' mental model of a specific reality is structured in terms of a predetermined cause-and-effect relationship (Human-Vogel, 2006). IQA was used in the present study as it allowed the researcher to develop a model of the participants' perceived relationship between their experience of and coping with abortion (Northcutt & McCoy, 2004). Even though IQA is primarily qualitative, it uses both inductive and deductive reasoning by means of concept mapping, grounded theory, action research and systems theory (Northcutt & McCoy, 2004). As IQA follows a set of accountable and systematic procedures, trustworthiness, validity and reliability are inherently addressed. Due to the vulnerability of the participants in this group, themes related to their experience and coping strategies were not discussed in a group context, but rather through individual interviews and structured questionnaires as indicated in the following sections.

Participants

The participants included an availability sample of 37 adult South African women between the ages of 18 and 35 years, from different races and cultures and from both rural and urban backgrounds who have had a legal induced abortion at the Reproductive Health Clinic at the Potchefstroom Hospital, North West province. All the participants were able to understand and express themselves in Setswana, English or Afrikaans; none were related to or known to the researcher; and none had had any illegal abortions. Participants were recruited through the head nurse at the Reproductive Health Clinic at the Potchefstroom Hospital. When the women first visited the Reproductive Health Clinic for the abortion, the

head nurse provided them with the necessary information on the research study and the informed consent letter. Once the participant expressed interest to partake in the research study, an appointment was scheduled to be conducted in a private room at the Potchefstroom Hospital's Counselling Centre.

The research was conducted in two phases. Six participants took part in the first phase (see table 1), which involved individual semi-structured interviews. All were black South African women between the ages of 19 and 28 years with a mean age of 25 years. Three of them spoke Setswana-, one Sepedi, one Sesotho and one isiZulu. Two were students, while the rest were unemployed and residing in and around or close to Potchefstroom. Only one of the participants had had a previous abortion, more or less ten years ago, at a legal clinic. The gestation period of their pregnancies ranged from 6 weeks to 10 weeks. None of the participants were rape victims.

Table 2: Biographical information of participants in stage 1

Participant	Age	Language	Occupation	Previous abortion	Gestation period
1	19	Setswana	Student	No	6 Weeks
2	25	Setswana	Unemployed	No	8 Weeks
3	22	Sepedi	Unemployed	No	8 Weeks
4	20	Setswana	Student	No	9 Weeks
5	28	isiZulu	Unemployed	No	6 Weeks
6	34	Sesotho	Unemployed	Yes	10 Weeks

During phase two, 32 participants took part, including one of the participants from phase 1. No specific biographic information is available for phase two participants, however, they were similar in age and background to those in phase 1.

Ethics

Ethics approval for this study was obtained from the Health Research Ethics Committee of the North-West University (ethics approval number NWU-00059-16-S1). The study was approved by the Health Department of South Africa and registered on the National Health Research Database. The researcher presented the study to the board at the Potchefstroom Hospital, where it received final approval. Research was conducted according to the research protocol of the North-West University. Each participant first gave their informed consent by signing an informed consent form prior to the research. Participation in this study was voluntary and anonymous. In addition, the participants were informed that they could withdraw from the research study at any stage without explaining why. Participants were also informed that the results of the study may be published, but that their identities will not be disclosed at any stage. Code names were used to ensure anonymity and all the data were captured on a password-protected computer.

The researcher firmly adhered to and noted the steps set out by Northcutt and McCoy (2004) to leave a complete audit trail. The first two authors independently generated the model as a form of member checking. Method triangulation was ensured by having one of the participants who completed the semi-structured in-depth interviews also complete the structured questionnaire.

Data collection and analysis

Data were collected and analysed in two phases. For the first phase, a total of six semi-structured individual interviews were conducted by the first author. The interviewer created a relaxed atmosphere where participants felt at ease to share intimate and confidential

information so that rich qualitative data could be generated (Northcutt & McCoy, 2004). The purpose of these semi-structured interviews was to compare the experiences and coping strategies of participants with those reported in the rapid review by Lyon and Botha (2018) and to identify common themes.

The interviewer started by discussing the information in the consent form with each participant again to establish trust and a sense of confidentiality:

- Biographical questions included: What is your mother language? How old are you? What is your current occupation? Where are you currently residing? Is this your first abortion? If not, how many times have you had an abortion before?

Questions regarding context, premorbidity and coping-related factors included: Please tell me a little bit more about yourself as a person, specifically in terms of how you perceive your strength and weaknesses. How do you see the role, if any, your community background played in any aspect of your abortion? What is your experience of the support or lack of support you received from family, parents, the medical team, friends and counsellors or anyone else? Please tell me about all the emotions or feelings, negative or positive, that you experienced before, during and after the abortion? Sometimes people also have positive experiences during challenging times in their lives. Is there anything in this regard that you want to share with me that relates to your experience during the abortion? How do you cope with the whole process – in other words, what do you do to be able to move on with your life and to regain or maintain your own sense of well-being, and to what extent are you successful in doing this? Based on our discussion today, what advice could you give health care workers involved in supporting those who undergo abortions?

Interviews took more or less 30 minutes to complete and were audio-recorded with the consent of the participants. Once the interviews had been completed, each interview was transcribed and thematically analysed according to the guidelines of Braun and Clarke (2006,

pp. 87-93). Termination of the pregnancy was pre-selected as a theme because within the IQA approach as it ensured that participants would specifically indicate how it featured as core issue in relation to their experiences and coping efforts with the event.

For the second phase, a structured questionnaire was developed based on the themes identified during the first phase to measure the perceived cause-and-effect relationship between the themes (Northcutt & McCoy, 2004). The questionnaire included a detailed explanation of the themes, followed by the items depicting the possible cause-and-effect relationship between all 13 themes. Each question compared two themes (coined affinities in IQA) and participants had to choose the relationship best describing their experience of and coping with abortion, for example:

$A \rightarrow B$ (Theme A causes theme B);

$A \leftarrow B$ (Theme B causes theme A); or

$A \text{ O } B$ (These themes are not related to each other).

The questionnaire took more or less 20 to 30 minutes to complete. The guidelines set out by Northcutt and McCoy (2004, pp. 160-163) were followed to analyse the results: First, the cumulative frequencies (CF) (see Table 4) were calculated by assigning the frequency of each relationship in descending order. Second, the cumulative percentage of relations (CPR) was calculated based on the total possible relationships between the 13 themes (78), where each relationship represented 1.282% or $1/78$. Third, the cumulative percentage frequency (CPF) of the total number of votes cast by the participants was calculated. Lastly, power (P), which represents the effectiveness of the system (Northcutt & McCoy, 2004) was calculated by subtracting CPR from CPF. The principle of parsimony (the fewest number of affinity pairs to represent the greatest amount of variation in the data) was then used to construct an interrelationship diagram (IRD) (Northcutt & McCoy, 2004). The strength of each relation in the IRD is expressed by delta (Δ), which determines the position of the themes in the mental

map. Themes with a positive Δ are relative drivers or causes and those with negative Δ are relative effects or outcomes (Northcutt & McCoy, 2004, pp. 173–184). The themes were arranged in descending delta value order to assign their placement in the first model or cluttered System Influence Diagram (SID). The final model was then developed by removing all redundant relationships according to the stepwise guidelines by Northcutt and McCoy (2004).

Results

Themes reflecting the experience of and coping with abortion.

One theme (termination of the pregnancy) was identified by the researchers while twelve themes were identified from the in-depth individual interviews. These were grouped into five categories (see Table 3).

Table 3: Categories and themes identified

Category	No	Theme
Negative emotions	1	Feeling anxious, scared or afraid
	2	Feeling traumatized to such an extent that I struggle to move forward
	3	Feeling sad or depressed
	4	Feeling guilt or regret
Termination of the pregnancy*	5	The abortion
Relationships	6	Tension with my family, community and culture
	7	Unsupportive or absent father of the baby
	8	Unhelpful nursing staff
Coping strategies	9	Subjective avoidance coping
	10	Religious coping
	11	Interpersonal avoidance coping
	12	Mutual coping through self-reflection
Positive emotions	13	Feeling of relief

The first category, **negative emotions**, included feeling anxious, scared or afraid; traumatized; sad or depressed; and feeling guilt or regret. All of the participants experienced some form of anxiety and fear throughout the abortion process, particularly during the abortion procedure itself and afterwards. In some instances, the participants made it clear that they were anxious because they did not know what to expect, for example *“I am even afraid that I will see it, because sometimes during the night I am asking that maybe this was the baby or what?”* and *“After I found out that I was pregnant I was googling the abortion thing”*. Their fear of the known was also evident: *“I was afraid of pain, cause I used to have extreme*

periods. I use to throw up, I use to have those extreme pains” and “I was scared, because they told me about the whole process and it got me scared. So it was worse when I went inside because I knew what they were going to do”.

Some of the participants experienced more than just fear or anxiety and described the abortion as a traumatic experience with persistent shock. As they attempted to move on with their lives they experienced recurring reminders to the abortion. This caused some of them to struggle to continue normally with their lives. One participant said: *“It was painful, eish I don’t know how to explain how it was, very bad, like very very bad. I would say traumatizing. I could not even have screamed out, but I sure would. I am having dreams; I am seeing babies when I am sleeping. I am having nightmares, it’s bad.”* Another participant explained it in the following way: *“It was painful and because it was the first time, like I didn’t know what was happening. It was kind of like traumatizing. Like seeing what they did.”*

Sadness or depression was also a common theme, specifically related to the experience of a sense of loss after having the abortion. One participant mentioned that she felt sad because she thinks that this could have been her only child: *“It is sad in a way, maybe this baby might be my only child, I wish things could be different.”* Other participants mentioned sadness in the following way: *“I was actually crying”, “I feel so sad”, “I cry, I cry a lot; and now I am really crying”, “I just felt down”, “The thought of killing my own baby, really I am sad”.* Some of the participants mentioned that they experienced a form of guilt or regret about their decision to have an abortion, for example: *“Eish I don’t know, I regret”, “There is a bit of regret in there, but it is done, what can I do?”, “I feel very guilty, because I killed an innocent soul for my own benefit”.* One participant, however, specifically mentioned that she had no regret about her decision: *“No regret about the decision”.*

The second category, **terminating the pregnancy**, was pre-selected (see data collection and analysis) and includes the decision to have an abortion and possible source of

participants' experiences and coping efforts. As it was pre-selected, it does not contain specific verbatim examples. All experiences were, however, directly linked to terminating the pregnancy.

The third category includes aspects related to **relationships** with important others. Firstly, participants indicated that they experienced tension with their families and their community and culture because they feel that they have disappointed them. They also explained that they experienced a fear of being rejected and judged, therefore they kept their decision to have an abortion a secret, which in turn led to lack of support from loved ones. Some examples include: *"They will just be disappointed and that is what I don't want my mother to go through"*; *"They will reject me, that is why I didn't tell anyone. In my culture it is not allowed"*, *"I didn't tell anyone about this, only my sister, and she told me that it is the wrong thing to do, but I did tell her I didn't have a choice"*, *"If I tell someone that person might tell everybody and then I wouldn't be able to walk on the streets"*.

Tension with the father of the baby, often prior to the unwanted pregnancy, emerged as a strong theme and were related to aspects like getting no support from him, infidelity, mistrust, abuse and lack of responsibility. This theme played a big role in the decision to have an abortion. It is clearly evident from the following: *"... if maybe I had support, I would not terminate"*, *"...I didn't know that he was married. He didn't tell me. So, the time I found out I tried to ask him, but he still lied to me. So, the time I found out I was pregnant I said no, I can't have someone's husband's child. That is why I had the abortion"*; *"He is drinking, he is going to tell me no this baby is not mine and what what what, I know him, he is very abusive. It is hurting me a lot, so I don't want anything from him, that is why I didn't tell him"*.

Unhelpful nursing staff also contributed to the abortion experience. One participant, for example, said: *"I think they should support us, not criticizing, you had sex knowing that you were going to have a child, now you want to abort! And all those nasty comments. I think they*

should support.” Other participants said: “Listen to the person, they must not shout at the person, because they don’t know how that person feels. They must be friendly, warm and welcoming.”, “They make it very hard for us, if they know it is already hard, they wouldn’t judge me like that. Because I don’t think there is someone who enter that door and say they want to do abortion with pride. You can’t be proud about it, so the way that they treat you they think that you are really proud of it or you couldn’t wait to do it. It is something that no one wants to do”.

The fourth category, **coping efforts**, includes: subjective avoidance coping; religious coping; interpersonal avoidance coping; and mutual coping through self-reflection. *Subjective avoidance coping* emerged as a prominent theme, with participants often trying to forget the experience by doing or thinking of something else: *“Most of the time I don’t want to think about that thing. So, it is not a lot of time that I think about that thing”*; *“Listening to the music I try to forget about it”*, *“I try to forget about it, when I think about it, I try to do something to occupy my mind. Like washing dishes or studying or going to a friend’s place”*, *“I just focus on other things that make me happy like my daughter”*.

Participants often used prayer as a form of *religious coping* with the abortion experience. Interestingly, this was regardless of the particular religion they followed. They expressed this in statements like: *“I just pray, I just pray to God to give me strength”*, *“I just pray to God that those consequences won’t happen”*, *“I just pray, I just pray to God to give me strength.”*

Interpersonal avoidance coping was another strong theme. Participants often isolated themselves due to the secret nature of the abortion. They were of the opinion that talking to others might reveal their secret of being sexually active and having an abortion: *“No I didn’t talk to anyone, I just want to be on my own”*, *“I can’t tell my parents like really how it is, I can’t. Even when people find out, I don’t like it when they really see what is really happening,*

I just don't like that", "I prefer not going to counselling, I don't like those things. I don't like someone questioning and making me cry and things like that", "Then you talk to people and then the next day they tell everyone, and you are being judged, that's why I just choose to keep quiet".

Mutual coping through self-reflection involved thoughtful decision making and sensitivity to others' approval. Their decision to have an abortion was solicitous and led to psychological growth, such as having new goals, being able to start a new life, lessons learned and not making the same decisions again. Examples of their self-reflective thoughts include: *"I was looking at everything surrounding me, everything I could bring this baby to. It is not right, it is really not right", "I was not financially stable, so I think if I decided to keep that baby, I don't want my baby to suffer. I just want like I want to be an example to her or him. I don't want him or her to say mom had me had me while she was 19 years old, she didn't go to university, she didn't have money so obviously he or she is going to follow my steps and don't want that. It was for my child's sake and for my sake and my mother's sake as well.", "The way I am, not having a job, having that type of a man, my family. What can I even do with this baby? At least when I had my first child, I was ready, and my family didn't judge that much because it was my first child, so they shout but it was not too much, and they were disappointed. To tell them that I have a second one again, what does that mean? It means that I am not even serious about trying to make something of my life, trying to build something with my life".* Mutual coping through self-reflection was also evident in the lessons they learned: *"Like I learned to stand by myself, like now I can say no use a condom. I don't want that mistake to happen again... I don't want to go through that thing again. It was a mistake and I need to rectify it not to do it again.", "I think it was the first time and the last time", "I would say that you should use contraceptive or you should abstain, just abstain.", "I should not have done this, I know better."*

The fifth and final category, **positive emotions**, consisted of only one theme, namely a sense of relief. Although this was not a strong theme, it was included in the structured questionnaire because of its significance in the rapid review (Lyon & Botha, 2018). One of the participants reported relief after the abortion: *“It was scary though, but at least it is over.”*

Perceived relationship between the themes.

Table 4 indicates that a total of 1152 votes were noted for the 156 possible relationships. The affinity pair 10←12 has the highest frequency (22), meaning that almost 70% of the participants perceived mutual coping through self-reflection to have caused / initiated religious coping. Only one affinity pair, 7 & 12 (causal direction in both ways) received no votes from any of the participants. Power reached a maximum value of 25.76 (‘Power’ column) at the 63rd affinity pair (10←13), which indicated that 40.38% (see CPR column) of the affinity pairs explained 66.15% of the variance of the data (see CPF column). All the affinities at the power turning point and above obtained a frequency of 8 or more.

Table 4: Frequency and power analysis of the relationships between themes.

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
10←12	22	43	0,64	3,73	3,09
4→10	21	64	1,28	5,56	4,27
10←11	21	85	1,92	7,38	5,46
1→10	20	105	2,56	9,11	6,55
5→10	20	125	3,20	10,85	7,65
9→10	20	145	3,84	12,59	8,74
3→10	18	163	4,48	14,15	9,66
4←5	18	181	5,12	15,71	10,58
2→10	17	198	5,76	17,19	11,42
5→13	16	214	6,41	18,58	12,17
5→9*	15	229	7,05	19,88	12,83
10→13*	15	244	7,69	21,18	13,49
1→2	14	258	8,33	22,40	14,06
3→9	14	272	8,97	23,61	14,64
3←12	14	286	9,61	24,83	15,21
1→9	13	299	10,25	25,95	15,70
2→9	13	312	10,89	27,08	16,19
9→13*	13	325	11,53	28,21	16,67
4←12	13	338	12,17	29,34	17,16
5→11	12	350	12,82	30,38	17,56
1←4	12	362	13,46	31,42	17,96
1←5	12	374	14,10	32,47	18,36

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
2←5	12	386	14,74	33,51	18,76
3←5	12	398	15,38	34,55	19,16
1→11	11	409	16,02	35,50	19,48
5→12*	11	420	16,66	36,46	19,79
12→13	11	431	17,30	37,41	20,11
1←3*	11	442	17,94	38,37	20,42
4←9*	11	453	18,58	39,32	20,73
9←12*	11	464	19,23	40,28	21,05
2→3	10	474	19,87	41,15	21,27
2→11	10	484	20,51	42,01	21,50
2→12*	10	494	21,15	42,88	21,73
6→11	10	504	21,79	43,75	21,96
11→13	10	514	22,43	44,62	22,18
1←12*	10	524	23,07	45,49	22,41
3←11	10	534	23,71	46,35	22,64
4←13	10	544	24,35	47,22	22,86
5←9*	10	554	25	48,09	23,09
9←11*	10	564	25,64	48,96	23,32
9←13*	10	574	26,28	49,83	23,54
1→12*	9	583	26,92	50,61	23,68
4→9*	9	592	27,56	51,39	23,82
6→10	9	601	28,20	52,17	23,97
7→10	9	610	28,84	52,95	24,11

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
9→11*	9	619	29,48	53,73	24,25
1←6	9	628	30,12	54,51	24,39
2←12*	9	637	30,76	55,30	24,53
3←4	9	646	31,41	56,08	24,67
3←6	9	655	32,05	56,86	24,81
4←6	9	664	32,69	57,64	24,95
4←11*	9	673	33,33	58,42	25,09
11←12	9	682	33,97	59,20	25,23
1→3*	8	690	34,61	59,90	25,28
4→11*	8	698	35,25	60,59	25,33
5→6	8	706	35,89	61,28	25,39
6→9	8	714	36,53	61,98	25,44
8→10	8	722	37,17	62,67	25,49
9→12*	8	730	37,82	63,37	25,55
2←4	8	738	38,46	64,06	25,60
3←7	8	746	39,10	64,76	25,65
5←12*	8	754	39,74	65,45	25,71
10←13**	8	762	40,38	66,15	25,76
1→5	7	769	41,02	66,75	25,73
3→5	7	776	41,66	67,36	25,69
3→11	7	783	42,30	67,97	25,66
3→13	7	790	42,94	68,58	25,63
6→12	7	797	43,58	69,18	25,59

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
11→12	7	804	44,23	69,79	25,56
1←8	7	811	44,87	70,40	25,53
1←9	7	818	45,51	71,01	25,49
2←3	7	825	46,15	71,61	25,46
4←10	7	832	46,79	72,22	25,43
5←13	7	839	47,43	72,83	25,39
1→4	6	845	48,07	73,35	25,27
1→7	6	851	48,71	73,87	25,15
7→9	6	857	49,35	74,39	25,03
10→12	6	863	50	74,91	24,91
1←11	6	869	50,64	75,43	24,79
3←9	6	875	51,28	75,95	24,67
3←10	6	881	51,92	76,48	24,55
4←7	6	887	52,56	77,00	24,43
5←10	6	893	53,20	77,52	24,31
6←10	6	899	53,84	78,04	24,19
7←10	6	905	54,48	78,56	24,07
1→13	5	910	55,12	78,99	23,86
2→4	5	915	55,76	79,43	23,66
2→5	5	920	56,41	79,86	23,45
2→6	5	925	57,05	80,30	23,24
2→13	5	930	57,69	80,73	23,04
3→4	5	935	58,33	81,16	22,83

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
3→8	5	940	58,97	81,60	22,62
3→12	5	945	59,61	82,03	22,42
4→12	5	950	60,25	82,47	22,21
7→11	5	955	60,89	82,90	22,00
8→11	5	960	61,53	83,33	21,79
8→12	5	965	62,17	83,77	21,59
1←10	5	970	62,82	84,20	21,38
2←7	5	975	63,46	84,64	21,17
2←8	5	980	64,10	85,07	20,97
2←9	5	985	64,74	85,50	20,76
2←13	5	990	65,38	85,94	20,55
5←7	5	995	66,02	86,37	20,35
6←11	5	1000	66,66	86,81	20,14
6←13	5	1005	67,30	87,24	19,93
7←9	5	1010	67,94	87,67	19,72
8←12	5	1015	68,58	88,11	19,52
9←10	5	1020	69,23	88,54	19,31
12←13	5	1025	69,87	88,98	19,10
2→8	4	1029	70,51	89,32	18,81
4→5	4	1033	71,15	89,67	18,52
4→6	4	1037	71,79	90,02	18,22
4→13	4	1041	72,43	90,36	17,93
6→13	4	1045	73,07	90,71	17,63

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
8→13	4	1049	73,71	91,06	17,34
2←6	4	1053	74,35	91,41	17,05
2←11	4	1057	75	91,75	16,75
3←8	4	1061	75,64	92,10	16,46
3←13	4	1065	76,28	92,45	16,17
4←8	4	1069	76,92	92,80	15,87
5←11	4	1073	77,56	93,14	15,58
6←12	4	1077	78,20	93,49	15,28
8←9	4	1081	78,84	93,84	14,99
11←13	4	1085	79,48	94,18	14,70
4→7	3	1088	80,12	94,44	14,32
5→7	3	1091	80,76	94,70	13,94
7→8	3	1094	81,41	94,97	13,56
8→9	3	1097	82,05	95,23	13,17
1←7	3	1100	82,69	95,49	12,79
2←10	3	1103	83,33	95,75	12,41
6←7	3	1106	83,97	96,01	12,03
7←11	3	1109	84,61	96,27	11,65
7←13	3	1112	85,25	96,53	11,27
8←10	3	1115	85,89	96,79	10,89
8←11	3	1118	86,53	97,05	10,51
1→6	2	1120	87,17	97,22	10,04
1→8	2	1122	87,82	97,40	9,58

Affinity Pair	Frequencies	Cumulative Frequency (CF)	Cumulative % Relation (CP)	Cumulative % Frequency (CPF)	Power
2→7	2	1124	88,46	97,57	9,11
3→6	2	1126	89,10	97,74	8,64
3→7	2	1128	89,74	97,92	8,17
6→7	2	1130	90,38	98,09	7,71
6→8	2	1132	91,02	98,26	7,24
7→13	2	1134	91,66	98,44	6,77
1←2	2	1136	92,30	98,61	6,30
5←6	2	1138	92,94	98,78	5,84
5←8	2	1140	93,58	98,96	5,37
6←8	2	1142	94,23	99,13	4,90
6←9	2	1144	94,87	99,31	4,43
7←8	2	1146	95,51	99,48	3,97
8←13	2	1148	96,15	99,65	3,50
4→8	1	1149	96,79	99,74	2,94
5→8	1	1150	97,43	99,83	2,39
10→11	1	1151	98,07	99,91	1,84
1←13	1	1152	98,71	100,00	1,28
7→12	0	1152	99,35	100,00	0,64
7←12	0	1152	100	100,00	0,00

Note: * Ambiguous or double pairings, but the highlighted relational pairs are the pairings that were included in the model since they had the higher frequency; ** Power turning point. Theme 1: Feeling anxious, scared or afraid; Theme 2: Feeling traumatized to such an extent that I struggle to move forward; Theme 3: Feeling sad or depressed; Theme 4: Feeling guilt or regret; Theme 5: The abortion; Theme 6: Tension with my family, community and culture; Theme 7: Unsupportive or absent father of the baby; Theme 8: Unhelpful nursing staff; Theme 9: Feeling of relief; Theme 10: I suppress or try to forget thoughts and emotions; Theme 11: I pray to God; Theme 12: I avoid talking to others, including family, friends and professionals; Theme 13: Self-reflection.

Figure 2 shows the power analysis of a total of 156 possible relationships (or affinity pairs). The 63 with the most votes by participants increased the power until a peak power point of 25.67 was reached, after that, power decreased.

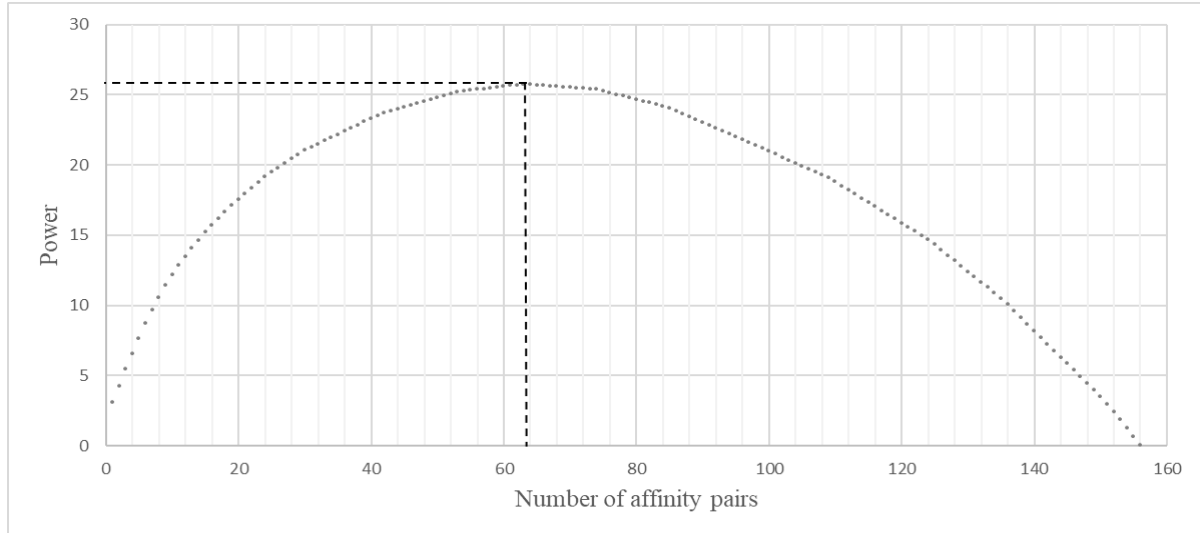


Figure 2: Power analysis

The inter-relational diagram (see Table 5) indicates the direction of the perceived relationships between the 13 themes. The delta values indicate that Theme 5 was the primary driver in the model and Themes 6, 12, 2, 7 and 8 were secondary drivers. This means that these represent the strongest causal themes. Themes 1, 4, 3, 9, 13 and 10 were secondary outcomes, while Theme 11 was a pivot. Themes with the same delta values (for example 2 & 7; and 3, 9 & 13) were placed according to IQA guidelines (Northcutt & McCoy, 2004).

Table 5: Inter-relational Diagram (IRD)

Theme	1	2	3	4	5	6	7	8	9	10	11	12	13	OUT	IN	DELTA
1	■	↑	←	←	←	←			↑	↑	↑	←		4	5	-1
2	←	■	↑	←	←				↑	↑	↑	↑		5	3	2
3	↑	←	■	←	←	←	←		↑	↑	←	←		3	7	-4
4	↑	↑	↑	■	←	←			←	↑	←	←	←	4	6	-2
5	↑	↑	↑	↑	■	↑			↑	↑	↑	↑	↑	10	0	10
6	↑		↑	↑	←	■			↑	↑	↑			6	1	5
7			↑				■			↑				2	0	2
8								■		↑				1	0	1
9	←	←	←	↑	←	←			■	↑	←	←	↑	3	7	-4
10	←	←	←	←	←	←	←	←	←	■	←	↑	↑	2	10	-8
11	←	←	↑	↑	←	←			↑	↑	■	←	↑	5	5	0
12	↑	←	↑	↑	←				↑	←	↑	■	↑	6	3	3
13				↑	←				←	←	←	←	■	1	5	-4

Based on the delta values, the first hypothetical model was developed with all relational pairs indicated in the IRD (see the tentative SID, Figure 3).

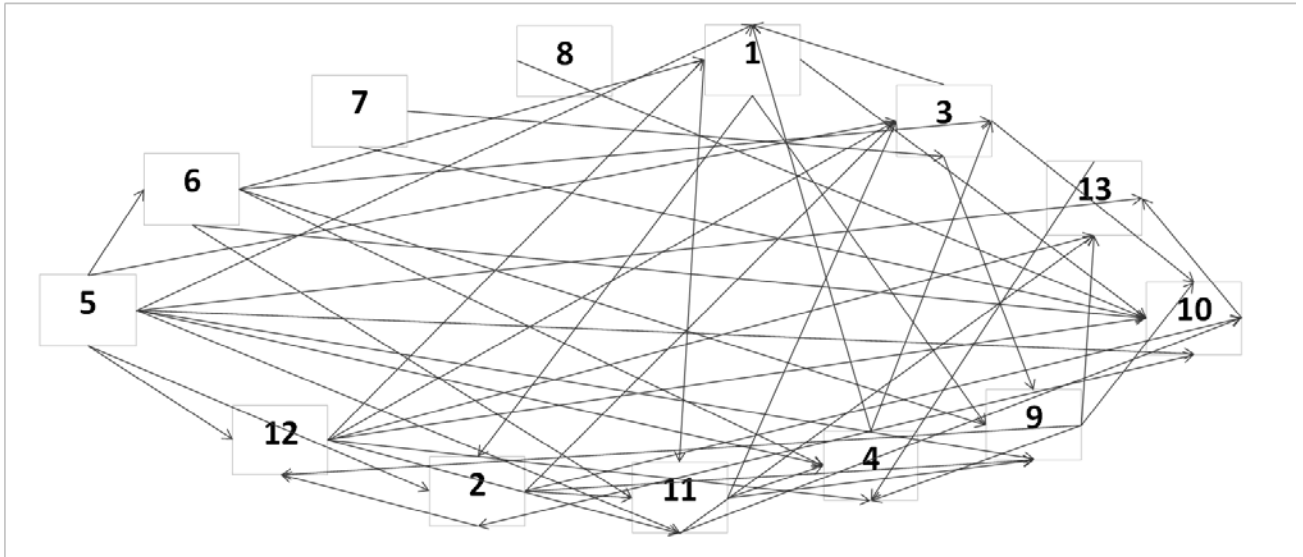


Figure 3: Tentative SID

The model was then refined by removing redundant links. Links were considered redundant when alternative routes were available between two affinities via an intermediary affinity (Northcutt & McCoy, 2004). A simplified system with ideal explicative capacity was created by removing redundant links (Bargate, 2014) (see cluttered SID, Figure 4).

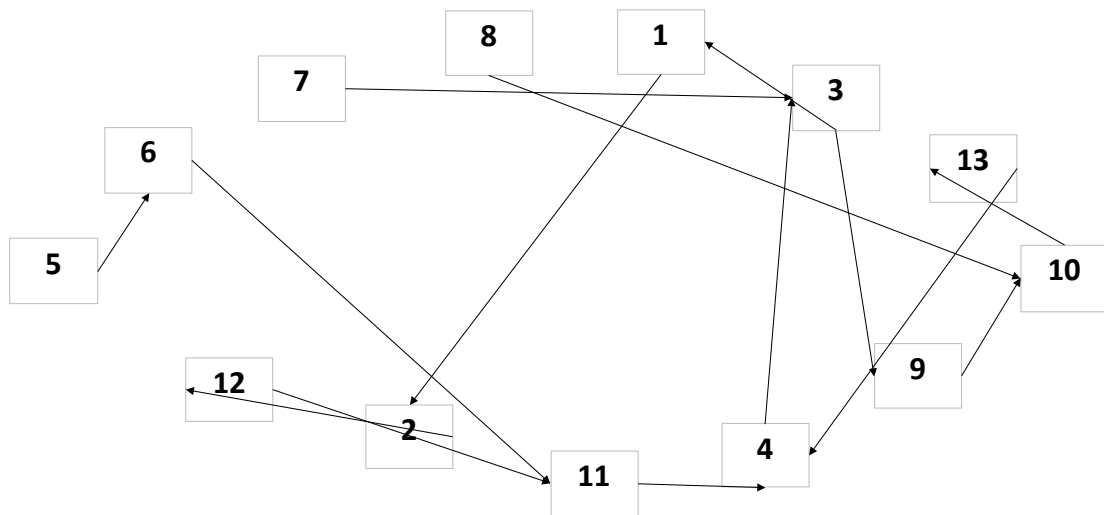


Figure 4: Cluttered SID

The final conceptual model is represented by the SID in Figure 5.

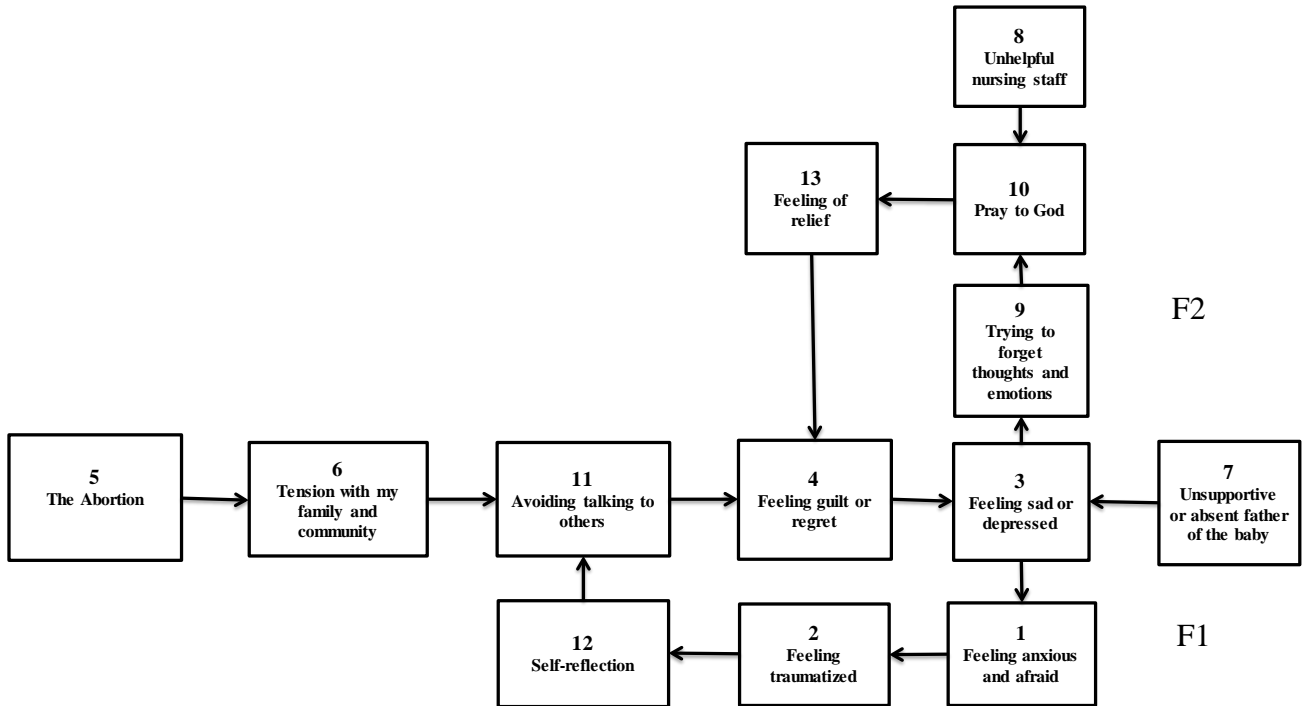


Figure 5: Final SID

This model serves as a hypothetical IQA model based on the experience of and coping with legal induced abortion of women in this sample. The model (Figure 5) shows a complex system of experience and coping efforts, characterized by two feedback loops. The abortion is perceived, not surprisingly, as the trigger or starting point of this process. The first consequence of the abortion is tension with the woman's family and community. This is followed by avoidance of communication (talking to others) and a feeling of guilt and regret. This in turn leads to feelings of sadness or depression, which are increased or maintained by an unsupportive father of the baby. Feeling sad or depressed creates two different feedback loops: The first feedback loop (F1 in Figure 5) seems to be related to an increase in anxiety and feeling traumatized, which causes the woman to self-reflect and eventually feeds back to the avoidance of communication with others. The second feedback loop (F2 in Figure 5) of feeling sad or depressed is initially characterized by denial or self-distancing (trying to forget emotions and thoughts), which, together with experiencing unsupportive nursing staff, causes

the woman to use religious coping as a coping effort. Although prayer causes a feeling of relief, it feeds back into their feelings of guilt or regret about what had happened.

Discussion

The 13 identified themes show that the participants in this study experienced abortion as a challenging process on both intra- and interpersonal levels. To fully comprehend their experience, the hypothetical model is used to explore how they perceive the interaction between the different themes, rather than focusing on the themes in isolation.

The model shows that the first perceived consequence of having the abortion is tension with the family and community. Halldén, Christensson and Olsson (2008) indicate that women who experience abortion are sensitive to the approval of others, especially the support from their parents in particular their mothers, partners and professionals. However, at the same time, they often feel or anticipate rejection as having an abortion is largely stigmatized in most contexts (Hanschmidt et al., 2016). Participants strongly indicated during the interviews that they were ashamed of revealing that they were sexually active because they feared what others would think, and that they would even be rejected for it. It is therefore no surprise that women who experience unwanted pregnancy and subsequently abortion, tend to keep their pregnancy a secret (Mookamedi, Mogotlane, & Roos, 2015) through non-disclosure (Cockrill & Nack, 2013) for fear of being socially stigmatized (Beynon-Jones, 2017). Consequently, this study confirms the interpersonal tension and lack of support women often experience as also indicated by previous research (Fingerer, 1973; Monsour & Stewart, 1973; Boulind & Edwards, 2008; Gray, 2015). From a self-regulation perspective, it seems as if an unwanted pregnancy and subsequent decision to abort creates a discrepancy between the participants' goals of social acceptance and support and what they think their family and the community will think of them as a result. In other words, the discrepancy

reflects a perceived dissimilarity between their need for support and how they really feel (unsupported).

The experience of social tension and avoidance, however, in turn causes participants to feel guilt and regret and subsequently sad and even depressed. This is not a surprise as a number of previous studies have also indicated that social processes such as stigma and lack of support leads to feelings of guilt, shame, anxiety, secrecy or unease about others' beliefs about abortion (Sa'nchez-Siancas, Rodri'guez-Medina, Piscoya, & Bernabe-Ortiz, 2018; Shellenberg & Tsui, 2012; Sullivan et al., 2017). Hanschmidt et al. (2016) further indicated that secrecy is associated with an increase in psychological distress and social isolation, while guilt may result from deciding to abort to finish school and to have a career (therefore experiencing a sense of selfishness) (Gray, 2015); feeling like a 'bad' person due to having unprotected and irresponsible sex (Gray, 2015; Harden & Ogden, 1999); uncertainty regarding future pregnancies and motherhood (Gray, 2015); feeling ashamed and fear of disappointment (Boulind & Edwards, 2008) and feelings of ambivalence about the abortion (Lundell et al., 2013).

It is understandable that the experience of distress and guilt may eventually cause feelings of sadness or depression. However, different reasons are indicated in the literature for this, for example poor mental health prior to the abortion (National Collaborating Centre for Mental Health [NCCMH], 2011), the abortion procedure itself (Subramaney et al., 2015), situational adjustment in the form of re-evaluation of learned beliefs regarding the abortion or due to the stigma surrounding abortion (NCCMH, 2011). Gray (2015), Curley and Johnston (2013), Boulind and Edwards (2008) and Fergusson, Horwood, and Ridder (2006) all reported that participants experienced some form of sadness or depression, whether due to situational circumstances or contextual factors such as stigma or due to the abortion itself. Interestingly, Boulind and Edwards (2008) mentioned that depression is worsened by feelings

of guilt and other factors unrelated to the abortion. According to Furnham, Ritchie, and Alixe, (2016) depression is often associated with the loss of something meaningful, such as a pregnancy or the goal to be a mother. The model also shows that participants perceive the unsupportive or absent father of the baby as contributing to feeling sad or depressed. This may link with the experience of social isolation and loss of important social support, or in terms of perceiving the father as the primary reason why the abortion took place, with associated feelings of anger and blame.

From a self-regulation perspective, the lack of support from the father of the baby contributes to the discrepancy between the goal of having a baby with someone you love and the reality of experiencing this event alone. These young women may in the process have realized that an important life goal to be a mother and to provide a good life for their child will not be achieved. The fulfilment of this goal may always have a negative association as a result. Effective self-regulation often does not imply achieving all of one's goals, but the ability to replace unachievable ones with others that are similar in value. With an abortion, this may be an extremely difficult, if not impossible, goal to replace.

Feeling sad or depressed results in two feedback loops. It is important to note that the presence of these two feedback loops (F1 and F2) does not mean that the participants necessarily made use of either F1 or F2. Any participant may rather have wavered between F1 and F2 at any time. In addition, it is possible that some participants may have followed one feedback loop and then shifted to the other or may have become "stuck" in one feedback loop.

The first feedback loop (F1) results in feeling anxious and afraid and subsequently traumatized. This leads to self-reflection by thinking deeply and contemplating what to do next, which in turn feeds back into the process of avoiding to talk to others while keep the abortion a secret. Anxiety in this phase of the process is therefore not surprising as it is often

associated with depression (Murphy et al., 2004), while the anxiety may also be the consequence of other continuous aspects of the abortion, for example stigma (Sa´nchez-Siancas et al., 2018); secrecy about the abortion (Gray, 2015); future pregnancy (Gray, 2015); being isolated (Gray, 2015; Harden & Ogden, 1999); and situational anxiety (Curley & Johnston, 2013). Moreover, when women experience both depression and anxiety to such an extent, it is also not surprising that they feel traumatized. From the individual interviews it was clear that the feeling of depression and anxiety made them aware of the intensity and repetitive thoughts about the abortion procedure, while for some feeling traumatized was the consequence of feeling immobilised and being unable to proverbially move forward with their lives. This supports the literature, as feeling traumatized is usually indicated as a sudden, unexpected experience of being overwhelmed by an event with no clear solutions (Briere & Scott, 2006).

Sadness, depression and anxiety often are the forerunners to a diminished capacity to strive towards achieving a goal and ultimately goal abandonment (Mann & De Ridder, 2013). Disengagement therefore usually follows the experience of sadness and anxiety (Carver & Scheier, 2013; 2016). However, women in this study tended to have engaged in self-reflection instead, a metacognitive process of self-evaluation and self-awareness (Robson, 2006). Zimmerman (2000) describes self-reflection as the final phase of self-regulation. According to Frydenberg (2017) self-reflection is also a type of meaning-focused coping. Self-reflection becomes apparent when a discrepancy is anticipated between set goals (for example longing to be supported in their abortion decision instead of being rejected or judged for it). The way in which one becomes aware of the discrepancy is by becoming aware of emotional discomfort (guilt or regret, sadness or depression and anxiety and fear). The experience of this emotional discomfort may indicate that reaching the goal of being accepted and supported by family and nursing staff may be threatened and adjustments are needed to

still reach the goal. Therefore, flexibility is required to adjust to either promoting positive outcomes or preventing negative ones (preventative coping). What is specifically required to effectively adjust after exposure to a life-changing event to reach one's goal is a state of stability and a sense of oneself (Zimmerman, 2000). From the interviews it was clear that the women in this study used self-reflection to make sense of themselves, their lives and their futures, and as an effort to cope with the discrepancy between longing to be supported and feeling unsupported with the resulting emotions of guilt, depression, anxiety and feeling traumatized. However, the result of self-reflection is perceived to result again in avoiding to talk to others, showing that the fear of being rejected or judged has not been adequately addressed through self-reflection. This is understandable given the fact that the participants are still in the process of processing the abortion experience. In the long run, however, socially engaging with others and sharing one's experience with people one trusts is an important resource in self-regulation (Zaki & Williams, 2013). Therefore, if their social disengagement continues, it may impede their self-regulation resources.

In the second feedback loop (F2), feeling sad or depressed resulted in the participants having suppressed or trying to forget their thoughts and emotions, followed by religious coping through the use of prayer. Previous research supports the use of suppressing thoughts and feelings in women during abortion (Boulind & Edwards, 2008; Curley & Johnston, 2013). Subjective avoidance coping strategies, such as trying to forget thoughts and emotions, reduces stress and the perception of threat (Leiner, Kearns, Jackson, Astin, & Rothbaum, 2012), but is construed as maladaptive in the long run and hinders recovery since it leads to emotional detachment, impedes suitable action (Hagenaars, Fisch, & Van Minnen, 2011) and may lead to problem behaviours such as risky sexual behaviour and substance use (Cooper, Wood, Orcutt, & Albino, 2003).

It is no surprise that women in this situation tend to make use of religious coping in the form of prayer in response to suppressing their thoughts and emotions and in reaction to unhelpful nursing staff, since it is an alternative to talking to others and it allows them to keep their abortion a secret. Furthermore, when these women experience stress after the abortion due to their limited available resources, prayer may play an important role in reappraising their goals and moving their focus away from feeling sad or depressed (Knabb & Vazquez, 2018). In a study on the experiences of women who have had abortions in Mpumalanga, South Africa (Mookamedi et al., 2015), some participants also reported praying in an effort to cope with the event, especially due to the religious stigma attached to abortion. Therefore, it seems to be understandable that prayer brings about relief to women in this position.

Several researchers report relief to be a predominant feeling that women often experience following an abortion (Boulind & Edwards, 2008; Fingerer, 1973; Gray, 2015; Halldén, Christensson, & Olsson, 2008; Harden & Ogden, 1999; Monsour & Stewart, 1973). This may theoretically be associated with a sense of agency as Bandura (2018) theorized that individuals have a sense of agency when they have the ability to shape their own surroundings and direction in life. However, in this study the relief the women experienced after prayer often led to renewed feelings of guilt and regret. The relief was therefore short-lived and may further confirm that, similar to feedback loop 1 where self-reflection fed back into avoidance of others, the women in this study were still in the process of working through the abortion experience.

Limitations

Before any conclusions can be drawn from the data presented in this paper, it is important to consider some limitations of the study. First, the study focused on one specific context, namely the Reproductive Health Clinic at the Potchefstroom Hospital. In addition, the participants were fairly homogenous, and only 6 were available for the first round of

interviews. One may therefore raise questions about the generalizability of the results. It should be noted, however, that Northcutt and McCoy (2004) recommend a participant group of between 8 and 16 for the first IQA phase (theme identification). A group of 6 was therefore not significantly smaller than this recommended amount. Furthermore, the aim of IQA is to develop a hypothetical model and not to determine a statistical reality. However, the results should still be interpreted carefully and not be generalized to any specific context.

Second, due to the ethical considerations involved in the sensitive topic of abortion, it was not possible to conduct the interviews within a focus / discussion group context as is normally the case in IQA. Identification of themes was therefore not possible within a group setting, but rather done by the two authors independently from the participants. To ensure trustworthiness, the IQA guidelines were strictly followed, while both authors critically reflected on any possible biases during the data analysis phase.

These limitations are not seen as significant, especially as the study in a general sense attempted to explore rather than to determine. The value and contribution of the study is that it provides new ways of looking at and understanding the complexities of the experience and coping with an abortion.

Conclusion and future research

The aim of this study was to explore how a sample of young adult South African women who had undergone an induced abortion perceived the relationship between different aspects of the experience and coping with it in their own situation, and to develop a conceptual, hypothetical model of the relationship between the different aspects of women's abortion experience and coping using an IQA method.

The 13 identified themes show that the participants in this study experienced abortion as a challenging process on both intra- and interpersonal levels. The most common themes all related to challenges, more specifically a range of negative emotions, social isolation and

rejection. Coping efforts seemed to be more subjective, inward-focusing, while a sense of relief emerged as the only positive consequence of the abortion. The themes are to a large extent similar to those that emerged as important in the rapid review by Lyon and Botha (2018), although the addition of a hypothetical model developed according to the IQA approach provided more depth, especially from a self-regulation perspective.

The model, which shows how participants perceive the cause-effect relationships between the 13 themes, clearly shows that the unwanted pregnancy and abortion is the starting point of an event that causes a discrepancy between important life goals, i.e. being a good mother in the future, having a career etc., and where the woman currently finds herself in dealing with an unwanted pregnancy. From a self-regulation perspective, being aware of a discrepancy motivates the individual to make changes, either in terms of their goals (accommodation) or in terms of their behaviour (assimilation), or sometimes aspects of both (Brandtstädter & Rothermund, 2002). The women in this study appeared mostly to have assimilated, in other words they still wanted to achieve their life goals, but they changed their behaviour in terms of firstly being proactive in trying to avoid telling others and protecting themselves from rejection and judgement. Using prayer and self-reflection are both forms of meaning-focused coping that often follows adverse events. It may be a protective factor against posttraumatic stress disorder and major depression (Frydenberg, 2017). Although their coping efforts could be perceived as steps towards integration of the abortion process and the initial development of a sense of agency, it still fed back into the challenge/difficulties they encountered without any clear healthy or positive results for them. The best possible explanation of this is that the women were still in the process of coping and even though avoidance and meaning-focused coping may have protected them from further adversity, something more appeared to be needed. Feeding back into the system is therefore not necessarily counterproductive as coping as self-regulatory process is intended to be

iterative and dynamic, unfolding over time (compare De Ridder & Kuijer, 2006). It could also be that the depression and anxiety they experienced were enhanced by premorbid factors like poverty and partner violence (Robinson et al., 2009), which required them to spend more time with the process. One would only be able to see whether growth has taken place when more time had lapsed. Only then would it be clear if, for example, the relief they experience, even if fleeting, eventually facilitated a broadening of resources and set them on trajectories of growth (Fredrickson, 2013).

In light of the aforementioned the following recommendations for future research are made: First, research should be done to explore the experience of and coping with abortion in different and more heterogenic contexts, both in South Africa and abroad. Second, research should be done to confirm the extent to which the model would hold true statistically, for example through structural equation modelling and large random samples. Third, more should be done to convert what we know about coping with abortion into abortion counselling programmes in South African clinics and hospitals. Finally, women who experience abortion should be treated without judgement and be provided with unconditional support as well as the necessary information regarding contraceptive usage.

References

- Aldwin, C. M., Skinner, E. A., Zimmer-Gembeck, M. J., & Taylor, A. (2011). Coping and self-regulation across the life span. In K. L. Fingerman, C. A. Berg, J. Smith, & T. C. Antonucci, *Handbook of life-span development* (pp. 561–587). New York: Springer Publishing Co.
- Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin*, *121*, 417–436.
- Bandura, A. (2018). Toward a psychology of human agency: Pathways and reflections. *Perspectives on Psychological Science*, *13*(2), 130-136.
- Bargate, K. (2014). Interactive qualitative analysis - a novel methodology for qualitative research. *Mediterranean Journal of Social Sciences*, *5*(20), 11–19.
- Berger, A. (2011). *Self-regulation: Brain, cognition and development*. Washington, DC: American Psychological Association.
- Beynon-Jones, S. M. (2017). Untroubling abortion: A discourse analysis of women's accounts. *Feminism & Psychology*, *27*, 225–242.
- Bhekisisa Mail and Guardian Centre for Health Journalism. (2017, November 20). *#SizaMap: Find a safe, legal abortion near you with this list of designated providers*. Retrieved from <http://bhekisisa.org/article/2017-11-20-sizamap-find-a-safe-legal-abortion-near-you-with-this-list-of-designated-providers-1>
- Bhekisisa Mail and Guardian Centre for Health Journalism. (2018, June 18). *Sexual and reproductive justice coalition*. Retrieved from http://srjc.org.za/wp-content/uploads/2018/06/i8jNT5fVReGoh4Uray3r_Bhekisisa_SafeAbortion_final_2018.pdf

- Birdsey, G., Crankshaw, T. L., Mould, S., & Ramklass, S. S. (2016). Unmet counselling need amongst women accessing an induced abortion service in Kwazulu-Natal, South Africa. *Contraception, 94*, 473–477.
- Boulind, M., & Edwards, D. (2008). The assessment and treatment of post-abortion syndrome: A systematic case study from South Africa. *Journal of Psychology in Africa, 18*(4), 539–548.
- Brandtstädter, J., & Rothermund, K. (2002). The life-course dynamics of goal pursuit and goal adjustment: A two-process framework. *Developmental Review, 22*(1), 117–150.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy*. Thousand Oaks, CA: Sage.
- Carver, C. S., & Scheier, M. F. (1998). *On the self-regulation of behavior*. New York, NY: Cambridge University Press.
- Carver, C. S., & Scheier, M. F. (2013). Goals and emotion. In M. D. Robinson, E. R. Watkins, & E. Harmon-Jones, *Handbook of cognition and emotion* (pp. 176–194). New York, NY: The Guilford Press.
- Carver, C. S., & Scheier, M. F. (2016). Self-regulation of action and affect. In K. D. Vohs, & R. F. Baumeister, *Handbook of self-regulation: Research, theory, and applications* (3rd ed., pp. 3–23). New York: Guilford Press.
- Carver, C. S., & Scheier, M. F. (2017). Self-regulatory functions supporting motivated action. In A. J. Elliot, *Advances in motivational science* (3rd ed., vol. 4, pp. 1–37). Cambridge, MA: Elsevier.

- Charles, V. E., Polis, C. B., Shridhara, S. K., & Blum, R. W. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception, 78*(6), 436–450.
- Cleary, T. J., Callan, G. L., & Zimmerman, B. J. (2012). Assessing self-regulation as cyclical, context-specific phenomenon: overview and analysis of SRL microanalytic protocols. *Education Research International*. doi:10.1155/2012/428639
- Cockrill, K., & Nack, A. (2013). 'I'm not that type of person'. Managing the stigma of having an abortion. *Deviant Behaviour, 34*(12), 973–990.
- Cooper, D., Dickson, K., Blanchard, K., Cullingworth, L., Mavimbela, N., von Mollendorf, C., Winikoff, B. (2005). Medical abortion: the possibilities for induction in public sector South Africa. *Reproductive Health Matters, 13*(26), 35–43.
- Cooper, D., Harries, J., Moodley, J., Constant, D., Hodes, R., Mathews, C., Hoffman, M. (2016). Coming of age? Women's sexual and reproductive health after twenty-one years of democracy in South Africa. *Reproductive Health Matters, 24*(48), 79–89.
- Cooper, M. L., Wood, P. K., Orcutt, H. K., & Albino, A. (2003). Personality and the predisposition to engage in risky or problem behaviors during adolescence. *Journal of Personality and Social Psychology, 84*, 390–410.
- Curley, M., & Johnston, C. (2013). The characteristics and severity of psychological distress after abortion among university students. *Journal of Behavioral Health Services and Research, 40*(3), 279.

- De Ridder, T. D., & Kuijer, R. G. (2006). Managing immediate needs in the pursuit of health goals: The role of coping in self-regulation. In D. De Ridder, & J. De Wit, *Self-regulation in health behavior* (pp. 147-168). Chichester: John Wiley.
- Fergusson, D. M., Horwood, L., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry*, 47(1), 16–24.
- Fingerer, M. E. (1973). Psychological sequelae of abortion: Anxiety and depression. *Journal of Community Psychology*, 1(2), 221–225.
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology*, 55, 745–774.
- Fredrickson, B.L. (2013) Updated thinking on positivity ratios. *American Psychologist*, 68(9), 814-822.
- Frydenberg, E. (2017). Spiritual approaches to coping and mindfulness. In E. Frydenberg. *Coping and the Challenge of Resilience*. (pp. 175-192). London: Palgrave.
- Furnham, A., Ritchie, W., & Alixe, L. (2016). Beliefs about the causes and cures of depression. *International Journal of Social Psychiatry*, 62(5), 415–424.
- Gray, J. B. (2015). “It has been a long journey from first knowing”: Narratives of unplanned pregnancy. *Journal of Health Communication*, 20(6), 736–742.
- Hagenaars, M. A., Fisch, I., & Van Minnen, A. (2011). The effect of trauma onset and frequency on PTSD-associated symptoms. *Journal of Affective Disorders*, 132, 192–199.
- Halldén, B., Christensson, K., & Olsson, P. (2008). Early abortion as narrated by young Swedish women. *Scandinavian Journal of Caring Sciences*, 23(2), 243–250.

- Hanschmidt, F., Linde, K., Hillbert, A., Riedel-Heller, S. G., & Kersting, A. (2016). Abortion stigma: A systematic review. *Perspectives on Sexual and Reproductive Health, 48*(4), 169–177.
- Harden, A., & Ogden, J. (1999). Young women's experience of arranging and having abortions. *Sociology of Health and Illness, 21*(4), 426.
- Harries, J., Cooper, D., Strebel, A., & Calvin, C. J. (2014). Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *Reproductive Health, 11*(16), 1–7.
- Human-Vogel, S. (2006). Students' mental models of positive mood and self-regulation in learning. *South African Journal of Psychology, 36*(3), 613–633.
- Kawonga, M., Blanchard, K., Cooper, D., Cullingworth, L., Dickson, K., Harrison, T., Winikoff, B. (2008). Integrating medical abortion into safe abortion services experience from three pilot sites in South Africa. *Journal of Family Planning and Reproductive Health Care, 34*(3), 159–164.
- Kimport, K., Foster, K., & Weitz, T.A. (2011). Social sources of women's emotional difficulty after abortion: lessons from a qualitative analysis of women's abortion narratives. *Perspectives on Sexual and Reproductive Health, 43*(2), 103-109.
- Knabb, J. J., & Vazquez, V. E. (2018). A randomized controlled trial of a 2-week internet-based contemplative prayer program for Christians with daily stress. *Spirituality in Clinical Practice, 5*(1), 37–53.
- Kumar, A., Hessini, L., & Mitchell, E. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality, 11*, 625–639.

Leiner, A. S., Kearns, M. C., Jackson, J. L., Astin, M. C., & Rothbaum, B. O. (2012).

Avoidant coping and treatment outcome in rape-related posttraumatic stress disorder.

Journal of Consulting and Clinical Psychology, 80, 317.

Lince-Deroche, N., Fetters, T., Sinanovic, E., & Blanchard, K. (2017). Accessing medical and surgical first-trimester abortion services: women's experiences and costs from an operations research study in KwaZulu-Natal Province, South Africa. *Contraception, 96*(2), 72–80.

Lince-Deroche, N., Pleaner, M., Harries, J., Morroni, C., Mullick, S., Firnhaber, C., Sinanovic, E. (2016). Achieving universal access to sexual and reproductive health services: the potential and pitfalls for contraceptive services in South Africa. *South African Health Review, 2016*(1), 95-108.

Little, T. D., Hawley, P. H., Henrich, C. C., & Marsland, K. W. (2002). Three views of the agentic self: A developmental synthesis. In E. L. Deci, & R. M. Ryan, *Handbook of Self-Determination Research* (p. 470). New York: University of Rochester Press.

Lundell, I. W., Öhman, S. G., Frans, Ö., Helström, L., Högberg, U., Nyberg, S., Svanberg, A. S. (2013). Posttraumatic stress among women after induced abortion: a Swedish multi-centre cohort study. *BMC Women's Health, 13*(1), 1–21.

Lyon, R., & Botha, K.F.H. (2018). The Experience of and Coping with Abortion: A Rapid Review. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 2). Unpublished doctoral thesis. North-West University, Potchefstroom.

Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health. *American Psychologist, 64*(9), 863–890.

- Major, B., Cozzarelli, C., Cooper, M. L., Zubek, J., Richards, C., Wilhite, M., & Gramzow, R. H. (2000). Psychological responses of women after first-trimester abortion. *Archives of General Psychiatry, 57*(8), 777–784.
- Major, B., Richards, C., Cooper, M. L., Cozzarelli, C., & Zubek, J. (1998). Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. *Journal of Personality and Social Psychology, 74*(3), 735–752.
- Mann, T., & De Ridder, D. (2013). Self-regulation of health behavior: Social psychological approaches to goal setting and goal striving. *Health Psychology, 32*(5), 487–498.
- McClelland, M. M., & Cameron, C. E. (2012). Self-regulation in early childhood: Improving conceptual clarity and developing ecologically valid measures. *Child Development Perspectives, 6*, 136–142.
- Monsour, K. J., & Stewart, B. (1973). Abortion and sexual behaviour in college women. *American Journal of Orthopsychiatry, 43*(5), 804–814.
- Mookamedi, R. E., Mogotlane, S. M., & Roos, J. H. (2015, November). The experience of women who undergo termination of pregnancy in Mpumalanga province, South Africa. *Africa Journal of Nursing and Midwifery, 17*, 146–161.
- Murphy, J. M., Horton, N. J., Laird, N. M., Monson, R. R., Sobol, A. M., & Leighton, A. H. (2004). Anxiety and depression: a 40-year perspective on relationships regarding prevalence, distribution, a comorbidity. *Acta Psychiatrica Scandinavica, 109*, 355–375.

- National Collaborating Centre for Mental Health (NCCMH). (2011, December). Induced abortion and mental health: A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors. *Academy of Medical Royal Colleges*. Retrieved from http://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf
- National Department of Health South Africa. (2017, May). *South Africa demographic and health survey*. Retrieved from <https://www.statssa.gov.za/publications/Report%2003-00-09/Report%2003-00-092016.pdf>
- Ndwambi, A., & Govender, I. (2015). Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal South Africa. *Southern African Journal of Infectious Diseases*, 30(4), 129–133.
- Northcutt, N., & McCoy, D. (2004). *Interactive qualitative analysis. A systems method for qualitative research*. London: Sage.
- Robinson, G. E., Stotland, N. L., Russo, N. F., Lang, J. A., & Occhiogrosso, M. (2009). Is there an "abortion trauma syndrome"? Critiquing the evidence. *Harvard Review of Psychiatry*, 17, 268–290.
- Robson, S. (2006). *Developing thinking and understanding in young children: An introduction for students*. Abingdon: Routledge.
- Sánchez-Siancas, L. E., Rodríguez-Medina, A., Piscocoya, A., & Bernabe-Ortiz, A. (2018). Association between perceived social support and induced abortion: A study in maternal health centers in Lima, Peru. *PLOS ONE*, 13(4), 1–11.

- Schwartz, R., & Taubert, S. (2002). Tenacious goal pursuits and striving toward personal growth: Proactive coping. In E. Frydenberg, *Beyond coping: Meeting goals, visions and challenges* (pp. 19–35). London: Oxford University Press.
- Sedgh, G., Singh, S., & Hussain, R. (2014). Intended and unintended pregnancies worldwide in 2012 and recent trends. *Studies in Family Planning*, 45(3), 310.
- Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among patients in the USA: An exploration by race and Hispanic ethnicity. *International journal of Gynecology and Obstetrics*, 118(2), 152–159.
- Subramaney, U., Wyatt, G. E., Williams, J. K., Zang, M., Liu, H., & Chin, D. (2015). Depressive and post-traumatic stress symptoms following termination of pregnancy in South African women: A longitudinal study measuring the effects of chronic burden, crisis support and resilience. *The South African Medical Journal*, 105(11), 934–938.
- Sullivan, M. E., Harrison, A., Harries, J., Sicwebu, N., Rosen, R. K., & Galarraga, O. (2017). Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study. *Health Care for Women International*, 1–14.
- Toriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, South Africa. *Africa Journal of Nursing and Midwifery*, 119-131.
- UnitedHealthcare. (2017). *Abortions (Therapeutic and Elective)*. Oxford: Oxford Health Plans, LLC.

Zaki, J., & Williams, W. C. (2013). Interpersonal emotion regulation. *Emotion*, 803–810.

doi:10.1037/a0033839

Zimmerman, B. J. (2000). Attaining self-regulation: A social cognitive perspective. In M.

Boekaerts, P. R. Pintrich, & M. Zeidner, *Handbook of self-regulation* (pp. 13–35).

San Diego: Academic Press.

CHAPTER 4: MANUSCRIPT 3**Towards the development of guidelines to facilitate effective coping in young adult women undergoing induced abortion in South Africa**

R. Lyon¹, K.F.H. Botha¹ & L.D. Preston²

1 School for Psychosocial Health, North-West University: Potchefstroom Campus

2 School for Psycho-Social Education, North-West University: Potchefstroom Campus

R. Lyon *

3078 Fish Eagle Ave, Parys Golf & Country Estate

Parys

9585

roche.lyon@gmail.com

*To whom correspondence should be addressed

Abstract

The aim of this article was to provide a starting point for the development of counselling guidelines to facilitate effective coping skills in young adult women undergoing an induced abortion in South Africa. The study was motivated by apparent current gaps in abortion care in South African public hospitals, such as the lack of counselling services, the strong presence of abortion stigma and a lack of knowledge or application of proactive coping skills in abortion counselling. A guideline-development approach supported by certain aspects of intervention development was followed to create scientifically sound guidelines specifically for South African public hospitals. The guidelines are based on three key change mechanisms, each implemented according to an integration of person-centred and strength-approach principles. Further research is needed to refine and evaluate these guidelines.

Keywords

Coping, induced abortion, counselling guidelines, termination of pregnancy, person-centred approach, strengths-perspective

Towards the development of guidelines to facilitate effective coping in young adult women undergoing induced abortion in South Africa

This article aimed to provide a starting point for the development of guidelines for counsellors working in South African public hospital abortion clinics to foster more effective coping skills among affected women. Induced abortion is defined as a medically induced miscarriage by means of medication or surgical procedures (Torriente, Joubert, & Steinberg, 2016). In South Africa the law enables women from the age of 12 years to terminate their pregnancies before the end of the first trimester (12 weeks of gestation) at a legal abortion provider (Choice on Termination of Pregnancy Act, 92 of 1996, see South Africa, 1996). The act further grants women the permission to make decisions about their reproductive health without the consent of their parents or partners. The main goal of the act is to promote the health and quality of life of women in South Africa (South Africa, 1996). When keeping the main goal of the act in mind, it is important to ensure that women's health and quality of life is considered and promoted during the abortion process.

Although a number of researchers (Cameron, 2010; Van Ditzhuijzen et al., 2017; Vincent, 2012) have indicated that the extent to which abortion directly contributes to mental health issues or pose any specific future mental health risks remain an unanswered question, it does not detract from the fact that abortion still poses some difficult challenges to those affected. In this regard, the psychological outcomes of abortion depend on each women's individual ability to cope effectively with the challenges it poses, especially for those women with pre morbid psychological problems (Quinley, Ratcliffe, & Schreiber, 2014). Coping with challenging circumstances in life is a vital characteristic of an individual (Straud, Mcnaughton-Cassill, & Fuhrman, 2015) and refers to an individual's ability to mobilize, modulate, manage and coordinate behaviour, emotions and attention while experiencing challenges or stress (Skinner & Zimmer-Gembeck, 2009). From this it is clear that coping

behaviour is self-regulatory in that it enables an individual to anticipate the occurrence of a challenge, like an abortion, and enables avoidance or minimization of the impact of that challenge (Berger, 2011). In this study, “effective coping” will therefore be defined as those strategies, skills or aspects of coping that proactively contribute to problem-solving, goal achievement, resilience and psychological well-being.

Pro-active coping focuses on the use of resources to facilitate personal growth prior to the experience of stress and not in reaction to a challenge or stressful situation (Roesch et al., 2009; Schwarzer & Knoll, 2003). It further integrates processes of personal quality of life management with those of self-regulatory goal attainment, by aiming to maximize gains and working towards handling future challenges in the best possible way (Schwarzer & Knoll, 2003). Proactive coping entails several potential benefits, therefore it can minimize the degree of stress experienced in a stressful situation and promote positive adaptation to stressors. Schwarzer (2001). Effective coping ultimately results in a sense of agency and the ability to make things happen through your own actions (Bandura, 2018). This enables an individual to rise above challenges and to be in control of shaping their environments and life courses. The implication for this study is that a sense of agency could be an important part of abortion counselling to help individuals to continue their lives in a constructive way, despite the challenges of the abortion.

Problem statement

Even though there are good fundamental international guidelines for pre-and post-abortion counselling and post-abortion care (IPPF, 2010; WHO, 2013; 2015), they tend to be broad, general and not necessarily applicable to the specific realities of developing countries such as South Africa, nor do they tend to provide guidelines specifically aimed at the fostering of constructive coping mechanisms that would prevent mental health issues and promote psychological well-being. In South Africa, there was no standard set of counselling

guidelines for public hospitals available while this study was conducted. However, valuable resources did exist: a step-by-step counselling guide (Mavuso et al., 2018) developed by the Critical Studies in Sexualities and Reproduction research unit of the Rhodes University and the Sexual and Reproductive Justice Coalition was available and based on abortion counselling practices in South Africa at the time which provided academic literature available on abortion counselling. Although these guidelines were closer to the realities of South Africa, they did not emphasize the facilitation of effective coping per se. Birdsey, Crankshaw, Mould and Ramklass (2016) further indicated that although participants experienced the group-based counselling format offered in KwaZulu-Natal as positive, it did not accommodate their differential counselling needs, like requests for support from women experiencing intimate partner violence.

It is therefore no surprise that Vincent (2012) emphasized that one of South Africa's limitations in the provision of abortion services is the lack of comprehensive abortion counselling guidelines or services. The author describes it as a "fraught terrain with ideological contestation" (p.126), often based on problematic assumptions about women, their bodies, their sexuality and their choices. The result is often anti-abortion counselling with the assumption that abortion causes psychological harm and that women are traumatized merely to support a specific political agenda. As a result, abortion counselling is often construed as crisis counselling, in contrast to strong evidence that psychiatric sequelae are not necessarily a given consequence of having an abortion.

As a result, a number of South African researchers emphasized the need for more research and the development of better quality abortion counselling skills (Birdsey et al., 2016; Mavuso, Du Toit, & Macleod, 2017; Vincent, 2012). This was supported by the researcher's observation of the counselling procedures at the Reproductive Health Clinic of the Potchefstroom Hospital in the North West province of South Africa, which only involved

basic counselling with limited available resources at the time. Therefore, when reviewing the guidelines set out in this article, the context of a South African public hospital should ideally be taken into consideration. Appropriate counselling guidelines could further contribute to the prevention of mental health issues and promote the psychological well-being of young women who experience abortion. It should therefore be aimed at more than just helping them “surviving the adversity”, but should rather provide them with the pro-active coping skills to grow and even flourish as part of the process.

The question this study wanted to address was therefore: What guidelines could be developed to facilitate effective coping in young adult women undergoing an induced abortion in South Africa? As a result, the aim was to conceptualize and provide a starting point for the development of counselling guidelines based on the findings of Lyon and Botha (2018) and Lyon, et al. (2018) for the fostering of effective coping in young adult women undergoing an induced abortion in South Africa. The development of the guidelines included blending existing research with relevant theories and knowledge to create scientifically sound guidelines.

Method

A particular guideline-development approach (Gagliardi, Marshall, Huckson, James & Moore, 2015; Wight, Wimbush, Jepson & Doi, 2016) was followed, supported by certain aspects of intervention development (Bartholomew Eldredge et al., 2016; Craig et al., 2008; Fraser & Galinsky, 2010) to increase the practical application value of the guidelines. Guidelines are documents that combine existing evidence on how to most effectively establish and deliver health services for a specific condition (Weisz et al., as cited in Gagliardi et al., 2015). The value of guidelines is that they could inform health decision making and serve as basis for policy, planning, and quality improvement (Gagliardi et al., 2015), but they should at the same time be flexible enough to be tailor-made to a specific

context. As such, the emphasis was not on a structured rigid intervention approach that stipulates training activities and guides the interaction between intervention agents and participants (Fraser & Galinsky, 2010) or on programme components like budget and time planning, policy-related issues or legal and ethical issues like consent (Bartholomew Eldredge et al., 2016). However, in line with strict programme and intervention principles, the development of guidelines was rigorous, systematic and aimed at goal-directed transformation plans (Fraser & Galinsky, 2010)

Data collection and Analysis: Steps in the development of the guidelines

The stepwise framework for the development of counselling guidelines were roughly based on the first four steps recommended by Wight et al. (2015) for the development of quality interventions. The final two steps (test and refine on small scale and collect evidence or effectiveness) of Wight's model were not followed as the intention was to develop guidelines and not to evaluate a programme or intervention. These first four steps are:

Define and understand the problem and its causes. The obvious starting point is identifying of the problem and its probable causes by examining the existing research evidence (Wight et al., 2015). This step was based on the problem statement and on those findings from Lyon and Botha (2018) and Lyon et al. (2018) that illustrated key areas in the abortion experience that were not adequately addressed by current counselling processes.

Clarify which causal or contextual factors are malleable and have the greatest scope for change. Step 2 is to identify which of the immediate or underlying factors identified in Step 1 has the greatest scope for change (Wight et al., 2015). This was done by comparing the issues that were inadequately addressed with the ways in which similar issues are dealt with effectively in other contexts.

Identify how to bring about change: the theory and change mechanisms. The third step is to determine how to achieve the desired change by developing a theory and identifying

change mechanisms (Wight et al., 2015). Developing a programme theory should be relevant and based on high quality data (Fraser & Galinsky, 2010; Medical Research Council, 2000) and should specifically provide an understanding of the foundation, sequencing and processes of change (Craig et al., 2008).

Identify how to deliver the change mechanism. Once the change mechanisms are identified, the final step requires working out how best to deliver the change mechanisms (Wight et al., 2015). This is also known as the implementation plan and requires clarification of the conditions and resources necessary for successful implementation and awareness of any related risks.

Ethics Issues and trustworthiness

Ethical approval for this research study was obtained from the Health Research Ethics Committee of the North-West University, (ethics approval number NWU-00059-16-S1). The researchers ensured trustworthiness and credibility by following Tracey's (2010) criteria for trustworthiness. First, rigour was addressed by spending adequate time, effort, care and thoroughness in developing the guidelines. The researchers engaged in continuous reflection on our own personal values, inclinations and biases regarding abortion in an effort to keep the study as sincere as possible. Furthermore, we strived to be honest and unambiguous with regard to the methodology, challenges and limitations of the study. To improve credibility, the guidelines were independently and thoroughly developed by the researchers, with continuous comparison, reflection and adjustment when and where appropriate. Finally, the study could have heuristic significance (compare Tracey, 2010, p.846) as it not only provided guidelines for the implementation of counselling principles, but hopefully also inspired some new perspectives on the experience of induced abortion.

Implementing and discussing the four steps of developing abortion counselling guidelines

This section provides a full explanation of the development of the guidelines. The guidelines itself appear in Addendum 1.

Step 1 - Define and understand the problem and its causes.

According to Wight et al. (2015), the obvious starting point is the identification of a problem and its probable causes according to the existing research evidence. This step was based on the problem statement and the findings from Lyon and Botha (2018) and Lyon et al. (2018). The study was firstly motivated by the following gaps in knowledge or practical application of abortion counselling in South Africa:

- The lack of available counselling services (Bhekisisa, 2017; Moore & Ellis, 2013; Trueman & Magwetshu, 2013);
- The strong stigmatization of abortion and negative attitudes towards abortion, even from health care providers (Bhekisisa, 2017; Hanschmidt, Linde, Hillbert, Riedel-Heller, & Kersting, 2016; Skosana, 2014; Upadhyay, Cockrill, & Freedman, 2010).
- The lack of international and local research, knowledge or application of abortion counselling from a coping and specifically a coping as self-regulatory behaviour perspective.

From a rapid review (Lyon & Botha, 2018) and interactive qualitative analysis (IQA) (Lyon et al., 2018) the following themes (shown in Table 1) emerged:

Table 6: Themes related to the experience of and coping with abortion

Theme	Lyon & Botha (2018)	Lyon et al. (2018)	Brief Description
1 Premorbid Factors	X		Poverty and partner violence negatively affect the experience of abortion. Personality may influence decision to abort
2 Social Stressors	X	x	Tension with family and community Lack of support The role of stigma
3 Ambivalence	X		Conflict about decision making
4 Lack of Autonomy and Control	X		Feeling overwhelmed by uncertainty regarding their unwanted pregnancy and decision making
5 Negative Emotions	X	x	Emotions such as: Depression Anxiety Guilt
6 Coping Strategies	X	x	Avoidance Self-reflection Prayer Lack of clear problem-focused coping.
7 Positive Emotions	X	x	Relief

Lyon and Botha (2018) revealed that in general, abortion is a complex emotional event that should be understood against the backdrop of every individual's unique circumstances. This is specifically true as an unwanted pregnancy and abortion are intertwined, and because the experience and coping efforts are greatly influenced by each

women's context (including culture), pre-abortion mental health and how they perceive and experience stigma from others. This supports the need for developing flexible guidelines rather than a specific programme or intervention.

Lyon et al. (2018) indicated further that young women at an abortion clinic in a South African public hospital have similar experiences to what emerged from the rapid review, but the analysis offered more depth: abortion is experienced as a challenging process on both intra- and interpersonal levels; a range of negative emotions and social isolation and even rejection was experienced; coping efforts seem to be more inward-focusing, while a sense of relief emerged as the only positive consequence of the abortion. The findings from Lyon and Botha (2018) and Lyon et al. (2018) supported research on premorbid factors (Sullivan, et al., 2017; Torriente et al., 2016; Ndwambi & Govender, 2015; Tinglöf, Högberg, Lundell, & Svanberg, 2015; Pallitto et al., 2012), stigma (Aantjes, Gilmoor, Syurina, & Crankshaw, 2018; Sullivan et al., 2017; Hanschmidt et al., 2016; Mookamedi, Mogotlane, & Roos, 2015; Shellenberg & Tsui, 2012; Upadhyay et al., 2010), lack of support (Sa'nchez-Siancas, Rodri'guez-Medina, Piscoya, & Bernabe-Ortiz, 2018), lack of sensitivity on the part of counsellors who hold anti-abortion views (Mavuso et al., 2017), negative emotions (Boersma, Van den Berg, Van Lunsen, & Laan, 2014; Foster, Steinberg, Roberts, & Neuhaus, 2015; Gomez, 2018; Mookamedi et al., 2015; Sullivan et al., 2017), personal growth (Kero, Högberg, & Lalos, 2004) and lack of autonomy and control (Charles, Polis, Shridhara, & Blum, 2008; Hanschmidt et al., 2016; Harries, Cooper, Strebel, & Calvin, 2014).

In addition to the isolated themes, an IQA model (Lyon et al., 2018) indicates that from a self-regulatory perspective, the unwanted pregnancy and abortion is the starting point of an event that causes a perceived discrepancy between important life goals and where the young women find themselves while dealing with the unwanted pregnancy. They appear to be still motivated to achieve their life goals and self-regulate by assimilation, therefore by

adapting their behaviour rather than giving up their goals. However, they do so by avoiding social interaction to protect themselves from stigma and rejection, which eventually, through further inward coping efforts, persistence of negative emotions, and unhelpful nursing staff, feeds back, despite some relief, into their negative affect. Although the participants in this study may perhaps just need more time with their coping effort, the results imply that their experience provides counsellors with the opportunity not only to prevent mental health issues from developing at a later stage, but also to improve their psychological well-being. The flipside of this is that absence of or poor counselling may leave these women with a number of potential unresolved issues that may exacerbate their vulnerability to either developing mental health issues or not being able to live their lives according to their potential.

Based on this, to complete Step 1, the problem and its causes, which the guidelines would eventually have to address, can be defined as follows: *Abortion is a complex experience, intertwined with the difficulty of the decision not to continue with an unwanted pregnancy, further complicated by social stigma, and specifically in a country like South Africa, lack of financial resources, partner violence, and absence of proper abortion counselling services. These factors challenge women's self-regulatory coping efforts to such an extent that psychological growth seems to be limited if the appropriate strengths within these women are not properly developed.* As such, guidelines for counselling should consider an awareness of and sensitivity to context. However, it should also focus on facilitating those aspects that would decrease the discrepancy women experience in a constructive, preventive and promotive way.

Step 2 - Clarify which causal or contextual factors are malleable and have the greatest scope for change.

It is extremely important for guidelines for effective abortion counselling in South Africa to be simple, straightforward and focused on those aspects that can be changed. From the conclusion provided in Step 1, it appears that the focus should be on those factors that the women themselves would be able to change and control to a certain extent. This would generally exclude external factors like poverty, interpersonal violence and stigma related to the abortion, and include more subjective, internal experiences and perceptions like ambivalence, lack of control and autonomy, negative and positive emotions, and coping strategies.

However, this does not mean that external factors could not be addressed through counselling, as these same factors (poverty, violence and stigma) are also exactly those contextual factors that were indicated in Step 1 as crucial for counsellors to be aware of and sensitive to. This is an important point that should be carefully considered in developing guidelines, especially in the light of the strong appeal by Curley (2010) and Mavuso et al. (2017) to focus on contextual factors, and Steinberg, Tschann, Furgerson and Harper (2016), who found a strong significant association between perceived abortion stigma and pre-abortion depressive, anxiety and stress symptoms. They also found pre-abortion psychological health to be the strongest predictor of post-abortion psychological health, and as such predict that reducing abortion stigma would promote post-abortion mental health. The best way to emphasize both contextual or external and internal experiences and perceptions is firstly to realize that these factors are interrelated, as external factors may influence internal experiences. Finally, a crucial factor that should be addressed during counselling is the counsellor's own insight, values and perceptions (Rubin & Russo, 2004; World Health Organization, 2013). To assist clients, counsellors must understand the politics of abortion

and the misinformation and myth-making involved in anti-abortion attempts to make abortion a stigmatized and stressful experience.

In conclusion, the factors that should receive attention can broadly be divided into three themes: First, external, contextual factors like a woman's background, culture, exposure to interpersonal violence, socio-economic status and perceived social stigma; second, internal experiences and perceptions of the client like their emotions (both positive and negative) and attributions, and finally, the internal values and perceptions of the counsellor, for example own ideas and biases about abortion, and their understanding of women's responses to the abortion.

Step 3 - Identify how to bring about change: the theory and change mechanisms.

This step involved determining how to achieve the desired change by developing a theory based on high quality data and identifying change mechanisms (Craig et al., 2008; Fraser & Galinsky, 2010; Medical Research Council, 2000; Wight et al., 2015). In addition, the central terms or concepts were defined to ensure a standard or uniform understanding (Craig et al., 2008) (Refer to the manual attached for the table of definitions of these central terms). Based on the findings of Lyon and Botha (2018) and Lyon, Botha and Preston (2018), it seems like a person-centred approach, integrated with a strength's perspective, would be most appropriate.

Person-centred approach. Although the recommendation to follow a person-centred approach in abortion counselling is not new, our research clearly emphasizes the importance and value of this approach. The approach was developed by Carl Rogers (1974) in the 1940s and emphasizes the counsellor-client relationship, empathy, the modelling of congruency and unconditional positive regard. Although it is applied as standalone psychotherapeutic approach, it is often also integrated within other psychotherapies, counselling frameworks and coaching techniques (Rogers, 1974). According to Yardley,

Ainsworth, Arden-Close and Muller (2015), a person-centred approach follows a sensitive mindfulness of the viewpoints and lives of the client through behaviour change interventions that provide insight into how different people may view different situations. The reason for recommending a person-centred approach is because of women's experience of abortion as a challenging process with associated stigma, social isolation, rejection, guilt and ambivalence (Lyon & Botha, 2018; Lyon et al., 2018). Ely (2007) indicates that women who are planning to or have already underwent an abortion seek a friendly atmosphere in which they feel accepted and not judged; a counsellor who normalizes their experience and who is capable of counteracting negative experiences; and a counsellor who is very knowledgeable about the procedure.

Strengths perspective. Counselling should in addition follow a strengths perspective, which emphasizes strengths rather than weaknesses or emotional pain (Biswas-Diener, Kashdan, & Minhas, 2011; Seligman, Rashid & Parks, 2006). The researchers could not find evidence of the strengths approach in previous literature on abortion counselling. A strengths approach is associated with positive psychology, which emerged as a corrective to traditional psychology's emphasis on pathology and illness. Positive psychology, and therefore a strengths approach, aims to enhance quality of life by focusing on already existing resources and promoting optimal functioning (Wissing, 2014). According to Govindji and Linley (2007), frequent use of strengths contributes to greater subjective and psychological well-being. The motivation for recommending a strengths-perspective is based on Vincent's (2012) argument that appropriate abortion counselling services in a country where freedom of religion, belief and conscience are constitutionally protected should take care that it does not proceed on the basis of contested assumptions about the "trauma" of abortion and the socially constructed guilt that goes along with it. Counselling to facilitate coping in young women should therefore be seen as the improvement of a

strength, and not the repair of dysfunctional coping. Therefore, to facilitate a broadening of resources (“broaden and build” theory, Fredrickson, 2013), counselling should be aimed at setting young women on trajectories of growth and building their enduring resources.

A combined person-centred approach and strengths perspective has the greatest potential to facilitate a sense of agency in clients. This refers to a person’s individual ability to make things happen by means of her own actions, shaping the events and the paths of her own life (Bandura, 2018). This is because, firstly, the client would experience acceptance and warmth from the counsellor, rather than stigma and rejection, and second, because a focus on strengths would hopefully enable the women to discover new aspects of themselves that they could embrace on continuing their lives. More specifically, it could facilitate a sense of agency regarding the management of goals related to motherhood, including taking responsibility for future pregnancies and contraception use.

Change mechanisms. The three aspects identified in Step 2 were selected as the key change mechanisms for the proposed guidelines since they are malleable and have the greatest scope for change. The success of each of these aspects (sensitivity to context, facilitating coping and counsellor’s self-reflection) will be dependent on the extent to which each is implemented according to a person-centred and a strengths approach. The result of this is a 2x3 conceptual grid (see Table 7).

Table 7: A summary of the three change mechanisms in relation to the theoretical approach

Change mechanisms	How to apply in counselling	
	Person-centred	Focused on strengths
1. Counsellor's ability to reflect on own biases	<i>Being self-congruent and inviting congruency from the client. Meeting the 'person' and not a 'patient'</i>	<i>Commit to the idea that clients do not necessarily need to be 'treated'. The aim of counselling should be facilitation of strengths and resources that already exist.</i>
2. Effectively understanding and reappraising context	<i>Unconditional positive regard. A trusting, supportive relationship with the client. Being sensitive to clients' context and differences in how context is appraised</i>	<i>Recognize client's ability to be resilient despite contextual challenges. Do not focus on what is wrong, but rather on what is "right", despite context.</i>
3. Effectively promoting clients' internal coping skills	<i>Allowing for expression of emotions through accurate reflection of feelings expressed by clients, especially negative emotions such as frustration, and difficulty in coping. Modelling flexible coping approaches.</i>	<i>Understand the importance of accurately acknowledging emotions, especially negative emotions like frustration in the context of coping as a self-regulatory process. Facilitate healthy coping.</i>

Change mechanism 1 – Counsellor's ability to reflect on own possible biases.

According to Rubin and Russo (2004), counsellors should recognize and put their own preconceived ideas about abortion aside. They must be clear about their own values, and if not possible, they should refer or not work in this context. They should avoid pre-judgement

about women's vulnerability or the assumption that they will necessarily find it difficult to cope. This links directly to a person-centred approach in which the counsellor, by being self-congruent or genuine, would model and invite congruency or genuineness from the client. This will allow for a trusting relationship in which both parties will meet each other as "persons" and not as "counsellor or client/patient".

Counsellors should also realize that even though abortion is a stressful event, most women are able to cope effectively with it (Rubin & Russo, 2004). They should therefore be careful not to assume that they are necessarily suffering from any form of psychopathology. Their goal should rather be to provide clients with the information, skills, support and confidence to improve their decision making and feeling of control and agency. Pretorius, Van Rooyen, and Reinbrech-Schutte (2010, p.4) explain the importance of unconditional positive regard, or a non-judgemental attitude as follows: "It is of vital importance that the health care provider understands that we not only assess and manage health in relation to the context in which we work, we also originate from and influence our context". A non-judgemental attitude that accepts that each client deserves the best help and should not be undermined by the consequences of subjective prejudice, is therefore crucially important. By understanding and committing to a strengths approach, the counsellor would further accept that clients do not necessarily need "treatment", but should rather be guided towards the facilitation of strengths and resources that already exist.

Change mechanism 2 – Understanding and reappraising context. It is of great importance that the counsellor considers the context of the unwanted pregnancy and the abortion, since the context often determines the experience and type of decisions that have to be made (Kilander, Berterö, Thor, Brynhildsen, & Alehagen, 2018; Upadhyay et al., 2010). When viewing the context, issues such as poverty or social disadvantage, partner violence and personality should be considered in a sensitive way, specifically in terms of how they

contribute to different client needs (Birdsey et al., 2016). The decision to have an abortion is often associated with isolation since these women avoid rejection and stigmatization (Pretorius et al., 2010; Hanschmidt et al., 2016).

As sensitivity to stigma and the lack of support is central, non-directive and supportive person-centred counselling is strongly advocated. According to Upadhyay et al. (2010), a client-centred approach would make it easier to tailor the counselling to both the context and individual needs of each client. It will help the counsellor to be sensitive to clients' context and to promote in clients a sense that they are being understood and engaged with as individuals with unique needs. In addition, when following a strengths approach, the clients' ability to be resilient despite contextual challenges is recognized. This focus on what is "right despite" rather than what is "wrong because" would be crucial in facilitating a pathway to well-being.

Change mechanism 3 – Promoting clients' coping skills in an effective way.

Whereas the first two mechanisms lay the foundation for change to take place, this mechanism is all about the facilitation of change itself. The first issue for counsellors to understand is the role emotions, and in particular negative emotions play in adverse situations and to guide clients towards an alternative appraisal. All women will respond to an abortion with a mixture of negative and positive emotions. The presence of negative emotions does therefore not necessarily mean having a psychological disorder. They are crucial in activating change as they provide both informational and processing effects, therefore acting as "mind modules" that produce adaptive benefits (Forgas, 2013, p.230). In this regard, whereas positive emotions reflect resilience and hope and build psychological resources over time (Guse, 2014), negative emotions act as a crucial resource in facilitating self-regulatory coping (Curley, 2010; IPPF, 2010).

From a person-centred perspective, the counsellor should therefore allow women to express all their, including negative emotions such as frustrations and difficulties in coping without judging or even indicating that these feelings imply an obstacle for growth. This can be done through accurate empathy being displayed by the counsellor by means of accurate reflection of the client's feelings during their interactions. Curley (2010) emphasizes how important it is that the counsellor ensures a safe counselling environment in which the client is informed about the normalcy of feeling out of control. The function of this should be a change in feeling restricted or even impaired by negative emotions to understanding and even feeling motivated by the direction negative emotions provide. From a strengths perspective, this initiates a process of "finding the positive in the negative" (Baumgardner & Crothers, 2010, p.46), first by positively reappraising the decision to abort and subsequent guilt feelings as an indication of the value they place on providing themselves with a better opportunity to raise a child, something they do not perceive possible in the current context. It may not always be possible to complete this meaning-making process within the time-limited constraints of abortion counselling; however, it is for each client to create at least some meaning from their experience before they would be able to move on.

Once their negative emotions are put in a new light, the validity of their current coping efforts (e.g. avoidance, prayer) should be acknowledged in an effort to teach and facilitate pro-active and problem-focused coping skills to ensure resilience in the long run. Firstly, they should be guided towards determining realistic, meaningful and attainable new life goals, for example regarding motherhood, relationships, family planning and contraceptive use. Goals are extremely important as they energize action and provide meaning, direction and purpose (Baumgardner & Crothers, 2010), while they also trigger pro-active and problem-focused coping because it is easier to detect obstacles or distractions in the context of having clear goals (Potgieter & Botha, 2014). Due to the negative experience

of an unwanted pregnancy and the choice to abort, young women may tend to choose avoidance goals, or negative outcomes one would want to avoid in the future such as the goal to never get pregnant again, or never to disappoint one's parents again. Scientific literature (Hennecke, 2018) is clear that approach goals are more important in creating a sense of purpose. Approach goals are positive outcomes one would like to achieve, for example, the goal to study again or start a new quality relationship with parents and friends.

Abortion counsellors therefore have to guide young women towards identifying approach rather than avoidance goals. Another benefit of approach goals is that they are easier to implement and self-regulate (Baumgardner & Crothers, 2010), and contribute strongly to pro-active and constructive coping efforts (Potgieter & Botha, 2014). According to Greenglass (2002), pro-active coping consists of efforts to build up general resources that facilitate the achievement of challenging goals and promote personal growth. It is further characterized by the ability to see risks, demands and opportunities in the future, but not to appraise these as threats or potential harm. Central to this is the ability to identify and activate social support as a general resource, because it may serve either as a buffer in the coping process or may directly improve well-being (Greenglass, 2002). In addition to this, counsellors also have to guide young women on how to flexibly apply different coping skills within different contexts. Flexibility seems to be a key feature in constructive coping as it creates a sense of autonomy and agency by increasing the options one has when anticipating or dealing with difficult situations (Potgieter & Botha, 2014). In this regard we concur with Swann and Jetten (2017) that a sense of agency is about providing people with more voice, additional choices and options, and additional time to take charge of their situations.

In summary, to improve their coping strategies, counsellors should provide support and validation, first by providing women with accurate, balanced information in a supportive setting to help their sense of self-efficacy and control; second by helping them to understand

that not all coping efforts are equally helpful; and third, by guiding them to identify alternative appraisals (Rubin & Russo, 2004).

Step 4 - Identify how to deliver the change mechanism.

The final step was to put all the information and elements together in an implementation framework, in other words, answering questions like where, who and what exactly?

Where? The study was motivated by what the researcher observed at a South African public hospital. In addition, Vincent (2012) points to previous studies that indicate that counselling was hard to initiate at South African public hospitals because counsellors often had to interact to women in a rushed and hurried manner due to a lack of staff and the women were often in too much of a hurry to receive comprehensive post-abortion counselling themselves. In addition, a large client load and inadequate space for private counselling contributed to the difficulty of providing adequate counselling and support. Therefore, the guidelines are specifically aimed at use within the context of South African public hospitals. It is important to realize that the counselling recommended here should be provided within a context of privacy and confidentiality. Therefore, it should be done in a private room during individual counselling sessions.

By whom? Since a woman who decides to have an abortion is typically alone and isolated, her first interaction would be with health care workers. Therefore, it is important that health care workers be tasked with helping and supporting her from the onset of the process. One challenge with abortion counselling is the fact that there are both medical procedures and psychological processes for which women need counselling. Ideally, this should be done by different counsellors who specialize in the different fields. Medical counselling to ensure safe abortion care and post-abortion contraception should preferably be

done by medical doctors, associate and advanced associate clinicians, midwives, nurses, auxiliary nurses and auxiliary nurse midwives (WHO, 2015), and psychological counselling by psychologists and psychological counsellors. However, as counsellors trained in psychology and counselling services are not always readily available at public hospitals (Sullivan et al., 2017), abortion counselling is often done by nursing staff with less emphasis on psychological processes. The guidelines developed in this study should therefore, in support of Mookamedi et al. (2015) be available to all health workers involved in abortion counselling at South African hospitals, especially for nursing staff members. However, it is strongly recommended that proper training be done before these guidelines are implemented, preferably by a registered psychologist or psychological counsellor.

For whom? Abortion is an emotionally noteworthy event in a woman's life and she is often isolated from the moment that she faces the abortion decision. These guidelines are for women who have already decided to undergo a legal induced abortion or have already underwent it at a public service provider in South Africa. Therefore, it is not intended for those women who are still in the process of being counselled on the different options they have and who have not yet committed to the procedure. The reason for this is that once a woman decides not to undergo an abortion, but to rather opt for completing the pregnancy and perhaps making use of foster care or adoption, a new set of challenges arise that fell outside the scope of the present study.

These guidelines would also not be applicable to all women. Although the authors believe that a person- and strengths approach would motivate more women to go for post-abortion counselling, many would perhaps still choose not to do so. Another option would be to include valid and reliable coping assessments under the supervision of the training psychologist during pre-abortion counselling to enable counsellors to decide when a woman should specifically be advised to attend post-abortion counselling.

When and how? South African law states that women seeking abortion should be provided with non-mandatory and non-directive pre- and post-abortion counselling and all the necessary information to enable them to make informed decisions (South Africa, 2008). These guidelines are aimed at supporting women through the whole abortion experience. Therefore, it is applicable to both pre- and post-abortion counselling. Since the researcher experienced that the majority of women do not return for post-abortion counselling and only for post-abortion physical examinations, these guidelines will serve an informative purpose during pre-abortion counselling (once the informed decision to abort has been made) and could serve as a guide for all health care workers for post-abortion check-ups and counselling.

The guidelines are further not meant to be a final set of “structured steps or activities”, but rather just initial guidelines for counsellors and/or health care workers at South African public hospitals. It could be integrated with their current procedures in a flexible manner. The idea is not to replace the standard pre- and post-abortion counselling, specifically regarding the medical aspects of the abortion. The ideal would therefore be, as already mentioned, that training should be provided to all staff who interact with these clients, especially nursing staff members for reasons already mentioned, on how to implement these guidelines in an appropriate, flexible way and when and how to refer when mental challenges do emerge.

Limitations and the way forward

The goal from the onset of this study was to provide a starting point for the development of counselling guidelines without evaluating them. This means that it is not known to what extent the guidelines would be effective. Another limitation of this study is that the guidelines are focused on the context of an abortion experience in a South African public hospital. Even though the guidelines are not rigid, they may not be generalizable to other contexts. This study does not claim either effectiveness or generalizability, as these aspects were outside the

scope of the current study. Furthermore, no counsellors were formally involved in developing the guidelines, even though the researcher spent long hours during data collection observing the context in which counselling takes place. The hope is that the guidelines will contribute to a more critical discourse, further research and eventually the successful implementation of more structured abortion counselling guidelines.

Given the aforementioned limitations, the most important recommendation is to do further research within similar contexts, to involve current counsellors to hear their “side of the story”, to include larger samples of women and perhaps also to do longitudinal studies to explore the long-term effect of abortion counselling. In addition, the guidelines developed in this study may be further refined by involving counsellors in a stepwise, Delphi-technique approach and by qualitatively and quantitatively evaluating its effectiveness.

Conclusion

In South Africa abortions occur frequently, which means that many women go through this experience on any given day. Despite the frequency of abortions, there is still a need for counselling guidelines for talking to women about the experience of and coping with abortion. The aim of this research study was to develop guidelines (Addendum 1) to facilitate effective coping in young adult South African women undergoing an induced abortion, based on the findings of Lyon and Botha (2018) and Lyon et al. (2018). The development of the guidelines involved integrating existing research with relevant theories and knowledge to create scientifically sound guidelines. A guideline-development approach was followed and further supported by certain aspects of intervention development. The guidelines developed were motivated by current gaps in South Africa’s abortion care, such as a shortage of counselling services, the strong presence of abortion stigma and a lack of knowledge or application of abortion counselling from the perspective of coping as self-regulatory behaviour. Three aspects were identified as key change mechanisms for the proposed

guidelines, namely the counsellor's self-reflection on their own biases, sensitivity to context, and the effective facilitation of coping skills. Each of these change mechanisms are dependent on the extent to which they are implemented according to an integration of both a person-centred and a strength approach. Further research on the evaluation of these guidelines is recommended to refine the guidelines and to determine their effectiveness.

References

- Aantjes, C. J., Gilmoor, A., Syurina, E. V., & Crankshaw, T. L. (2018). The status of provision of post abortion care services for women and girls in Eastern and Southern Africa: a systematic review. *Contraception*, *98*, 77-88.
- Bandura, A. (2018). Toward a Psychology of Human Agency: Pathways and Reflections. *Perspectives on Psychological Science*, *13*(2), 130-136.
- Bartholomew Eldredge, L., Markham, C., Ruitter, R., Fernandez, M., Kok, G., & Parcel, G. (2016). *Planning Health Promotion Programs. An Intervention Mapping Approach* (4th ed.). ProQuest Ebook Central: John Wiley & Sons.
- Baumgardner, S., & Crothers, M. (2010). *Positive Psychology*. Upper Saddle River: Pearson.
- Berger, A. (2011). *Self-regulation: Brain, cognition and development*. Washington DC: American Psychological Association.
- Bhekisisa. (2017, November 20). #SizaMap: Find a safe, legal abortion near you with this list of designated providers. Retrieved from <http://bhekisisa.org/article/2017-11-20-sizamap-find-a-safe-legal-abortion-near-you-with-this-list-of-designated-providers-1>
- Bhekisisa Mail and Guardian Centre for Health Journalism. (2018, June 18). *Sexual and Reproductive Justice Coalition*. Retrieved from Abortion in South Africa: http://srjc.org.za/wp-content/uploads/2018/06/i8jNT5fVReGoh4Uray3r_Bhekisisa_SafeAbortion_final_2018.pdf
- Birdsey, G., Crankshaw, T. L., Mould, S., & Ramklass, S. S. (2016). Unmet counselling need amongst women accessing an induced abortion service in Kwazulu-Natal, South Africa. *Contraception*, *94*, 473-477.

- Biswas-Diener, R., Kashdan, T., & Minhas, G. (2011). A dynamic approach to psychological strength development and intervention. *The Journal of Positive Psychology, 6*(2), 106-118.
- Boersma, A. A., van den Berg, D., van Lunsen, R. H., & Laan, E. T. (2014). Induced abortion is not associated with a higher likelihood of depression in Curaçao women. *The European Journal of Contraception and Reproductive Health Care, 19*, 359-367.
- Cameron, S. (2010). Induced abortion and psychological sequelae. Best Practice and Research . *Clinical Obstetrics and Gynecology, 24*, 657-665.
- Charles, V. E., Polis, C. B., Shridhara, S. K., & Blum, R. W. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception, 78*(6), 436-450.
- Choice on Termination of Pregnancy Act 92 of 1996 see South Africa. (1996).
- Choice on Termination of Pregnancy Amendment Act 1 of 2008 see South Africa. (2008).
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ Journal, 979-983*.
- Curley, M. (2010). *Psychological distress after abortion among university students: Developing an intervention* (Vol. 72). Montreal: ProQuest Information & Learning.
- Ely, E. (2007). The Abortion Counselling Experience: A Discussion of Patient Narratives and Recommendations for Best Practices. *Best Practices in Mental Health, 3*(2).
- Forgas, J. (2013). Don't worry, be sad! On the cognitive motivational and interpersonal benefits of negative mood. *Current Directions in Psychological Science, 22*.

- Foster, D. G., Steinberg, J. R., Roberts, S. C., & Neuhaus, J. (2015). A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychological Medicine, 45*(10), 2073-2082.
- Fraser, M. W., & Galinsky, M. J. (2010). Steps in Intervention Research: Designing and Developing Social Programs. *Research on Social Work Practice, 20*(5), 459-466.
- Gagliardi, A.R., Marshall, C., Huckson, S., James, R., & Moor, V. (2015). Developing a checklist for guideline implementation planning: review and synthesis of guideline development and implementation advice. *Implementation Science, 10*(19), 1-9.
- Gomez, A. M. (2018). Abortion and subsequent depressive symptoms: an analysis of the National Longitudinal Study of Adolescent Health. *Psychological Medicine, 48*(2), 294-304.
- Govindji, R., & Linley, P. A. (2007). Strengths use, self-concordance and well-being: Implications for strengths coaching and coaching psychologists. *International Coaching Psychology Review, 2*(2), 143-153.
- Greenglass, E. R. (2002). Proactive Coping. In E. Frydenberg, *Beyond coping: Meeting goals, vision and challenges* (pp. 37-62). London: Oxford University Press.
- Guse, T. (2014). Activities and programmes to enhance well-being. In M. Wissing, J. Potgieter, T. Guse, T. Khumalo, & I. Nel, *Towards Flourishing: Contextualising Positive Psychology* (pp. 291-314). Pretoria: van Schaik.
- Hanschmidt, F., Linde, K., Hillbert, A., Riedel-Heller, S. G., & Kersting, A. (2016). Abortion Stigma: A Systematic Review. *Perspectives on Sexual and Reproductive Health, 48*(4), 169-177.

- Harries, J., Cooper, D., Strebel, A., & Calvin, C. J. (2014). Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *Reproductive Health, 11*(1).
- Hennecke, M. (2018). What Doesn't Kill You...: Means for Avoidance Goal Pursuit Are Less Enjoyable Than Means for Approach Goal Pursuit. *Motivational Science*.
- International Planned Parenthood Federation. (2010, May 2). *First Trimester Abortion Guidelines and Protocols*. Retrieved from International Planned Parenthood Federation: <https://www.ippf.org/resource/first-trimester-abortion-guidelines-and-protocols>
- Kero, A., Högberg, U., & Lalos, A. (2004). Wellbeing and mental growth - long-term effects of legal abortion. *Social Science and Medicine, 58*(12), 2559-2569.
- Kilander, H., Berterö, C., Thor, J., Brynhildsen, J., & Alehagen, S. (2018). Women's experiences of contraceptive counselling in the context of an abortion - An interview study. *Sexual and Reproductive Healthcare, 17*, 103-107.
- Lyon, R., & Botha, K.F.H. (2018). The experience of and coping with abortion: A rapid review. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 2). Unpublished doctoral thesis. North-West University, Potchefstroom.
- Lyon, R., Botha, K.F.H., & Preston, L.D. (2018). The experience and coping strategies of a group of South African women who had an induced abortion. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 3). Unpublished doctoral thesis. North-West University, Potchefstroom.

- Major, B., & Schmader, T. (2001). Legitimacy and the Construal of Social Disadvantage. In J. T. Jost, & B. Major, *The Psychology of Legitimacy: Emerging Perspectives on Ideology, Justice, and Intergroup Relations* (p. 176). Cambridge: Cambridge University Press.
- Mavuso, J. M., du Toit, R., & Macleod, C. I. (2017, September). *Critical Studies in Sexualities and Reproduction Research Programme*. Retrieved from Rhodes University:
https://www.ru.ac.za/media/rhodesuniversity/content/criticalstudiesinsexualitiesandreproduction/documents/20180926_PolicyBrief_PreAbortionCounselling.pdf
- Mavuso, J. M., Du Toit, R., Macleod, C. I., & Stevens, M. (2018, July 24). Retrieved from Sexual and Reproductive Justice Coalition: <https://srjc.org.za/2018/07/24/abortion-counselling-in-south-africa-a-step-by-step-guide-for-providers-2/>
- Medical Research Council. (2000). *A framework for the development and evaluation of RTC's for complex interventions to improve health*. London: MRC.
- Mookamedi, R. E., Mogotlane, S. M., & Roos, J. H. (2015, November). The experience of women who undergo termination of pregnancy in Mpumalanga Province, South Africa. *Africa Journal of Nursing and Midwifery*, 17, 146-161.
- Moore, J., & Ellis, E. (2013, January 21). *In South Africa, A Liberal Abortion Law Doesn't Guarantee Access*. Retrieved from The Nation:
<https://www.thenation.com/article/south-africa-liberal-abortion-law-doesnt-guarantee-access/>

- Ndwambi, A., & Govender, I. (2015). Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal South Africa. *Southern African Journal of Infectious Diseases*, 30(4), 129-133.
- Pallitto, C. C., García-Moreno, C., Jansen, H. A., Heise, L., Ellsberg, M., & Watts, C. (2012). Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence. *International Journal of Gynecology and Obstetrics*, 120(1), 3-9.
- Potgieter, J., & Botha, K. (2014). Functioning Well. In M. Wissing, J. Potgieter, T. Guse, T. Kumalo, & L. Nel, *Towards Flourishing: Contextualising Positive Psychology* (pp. 39-76). Pretoria: van Schaik.
- Pretorius, D., van Rooyen, M., & Reinbrech-Schutte, A. (2010). *Patient-Centred Communication and Counselling: Principles and Practice*. Cape Town: Juta & Company Ltd.
- Quinley, K., Ratcliffe, J., & Schreiber, C. (2014). Psychological coping in the immediate post-abortion period. *Journal of Women's Health*, 23(1), 44-50.
- Roesch, S. C., Aldridge, A. A., Huff, T. L., Langner, K., Villodas, F., & Brandshaw, K. (2009). On the dimensionality of the Proactive Coping Inventory: 7, 5, 3 factors? *Anxiety, Stress & Coping*, 22, 327-339.
- Rogers, C. R. (1974). A Theory of Therapy and Personality Change: As Developed in the Client-Centred Framework. In R. Morris (Ed.), *Perspectives in Abnormal Behavior* (pp. 341-350). New York: Pergamon Press Inc.

- Rubin, L., & Russo, N. (2004). Abortion and Mental Health: What Therapists need to know. *Women & Therapy, 27*(3/4), 9-90.
- Sa´nchez-Siancas, L. E., Rodrı´guez-Medina, A., Piscocoya, A., & Bernabe-Ortiz, A. (2018). Association between perceived social support and induced abortion: A study in maternal health centers in Lima, Peru. *PLOS ONE, 13*(4), 1-11.
- Schwarzer, R., & Knoll, N. (2003). Positive Coping: Mastering Demands and Searching for Meaning. In S. J. Lopez, & C. R. Snyder, *Handbook of Positive Psychological Assessment*. Washington, DC: American Psychological Association.
- Seligman, M., Rashid, T., & Parks, A. (2006). Positive psychotherapy. *American Psychologist, 61*, 774-788.
- Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among patients in the USA: An exploration by race and Hispanic ethnicity. *International journal of Gynecology and Obstetrics, 118*(2), 152-159.
- Skinner, E. A., & Zimmer-Gembeck, M. J. (2009). Challenges to the developmental study of coping. In E. A. Skinner, & M. J. Zimmer-Gembeck, *Coping and the development of regulation. New directions for Child and Adolescent Development* (pp. 5-17). San Francisco: Jossey-Bass.
- Skosana, I. (2014, September 26). *Abortion turns into a nightmare*. Retrieved from Mail and Gaurdian Africa's Best Read: <http://mg.co.za/article/2014-09-26-abortion-turns-into-a-nightmare>
- South Africa. (1996). *Choice on Termination of Pregnancy Act, 92 of 1996*. Pretoria: Government Printer.

South Africa. (2008). *Choice on Termination of Pregnancy Amendment Act*, 1 of 2008.

Pretoria: Government Printer.

Steinberg, J., Tschann, J., Furgerson, D., & Harper, C. (2016). Psychosocial factors and pre-abortion psychological health: The significance of stigma. *Social Science Medicine*, 67-75. doi:10.1016/j.socscimed.2015.12.007

Straud, C., Mcnaughton-Cassill, M., & Fuhrman, R. (2015). The role of the five factor model of personality with proactive coping and preventative coping among college students. *Personality and Individual Differences*, 83, 60-64.

Sullivan, M. E., Harrison, A., Harries, J., Sicwebu, N., Rosen, R. K., & Galarraga, O. (2017). Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study. *Health Care for Women International*. doi:10.1080/07399332.2017.1400034

Swann, W., & Jetten, J. (2017). Restoring agency to the human actor. *Perspectives on Psychological Science*, 12(3), 382-399.

Tingl f, S., H gberg, U., Lundell, I. W., & Svanberg, A. S. (2015). Exposure to violence among women with unwanted pregnancies and the association with post-traumatic stress disorder, symptoms of anxiety and depression. *Sexual and Reproductive Healthcare*, 6(2), 50-53.

Torriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, South Africa. *Africa Journal of Nursing and Midwifery*, 119-131.

- Tracey, J. S. (2010). Qualitative Quality: Eight "Big Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, 16, 837-851.
- Trueman, K. A., & Magwetsu, M. (2013). Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa. *American Journal of Public Health*, 397-399.
- Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010). Informing Abortion Counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Education and Counseling*, 81, 415-421.
- van Ditzhuijzen, J., ten Have, M., de Graaf, R., Lutig, P., van Nijnatten, C. H., & Vollebergh, W. A. (2017). Incidence and recurrence of common mental disorders after abortion: Results from a prospective cohort study. *Journal of Psychiatric Research*, 84, 200-206.
- Vincent, L. (2012). Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order - a view from South Africa. *Culture, Health and Sexuality*, 14(2), 125-138.
- Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2016). Six steps in quality intervention development. *Journal of Epidemiological Community Health*, 70(5), 520-525.
- Wissing, M. (2014). A Path Towards Flourishing. In M. Wissing, J. Potgieter, T. Guse, T. Kumalo, & L. Nel, *Towards Flourishing: Contextualising Positive Psychology* (pp. 3-15). Pretoria: Van Schaik Publishers.

World Health Organization. (2013). Post-abortion Care. In W. H. Organization, *A Handbook for Building Skills: Counselling for Maternal and Newborn Health Care* (pp. 103-112). Geneva: World Health Organization Press.

World Health Organisation. (2015). *Health worker roles in providing safe abortion care and post-abortion contraception*. Retrieved from World Health Organisation:
http://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=2D3AA66C5F642CB8A527D442B1152658?sequence=1

Yardley, L., Ainsworth, B., Arden-Close, E., & Muller, I. (2015). The person-based approach to enhancing the acceptability and feasibility of interventions. *Pilot and Feasibility Studies*, 1(37), 1-7. DOI: [10.1186/s40814-015-0033-z](https://doi.org/10.1186/s40814-015-0033-z)

CHAPTER 5 SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Introduction

This final chapter summarizes the findings of the study, offers a conclusion and recommends the way forward for research and clinical practice. The study was motivated by three key aspects (Chapter 1):

- Despite South Africa's progressive abortion law, the **promise of access** has not yet turned into services that are available and/or successfully delivered (Moore & Ellis, 2013; Vincent, 2012). From a possible 5 048 public health facilities where abortions could potentially be offered, only 197 provided abortion services in 2017 (Bhekisisa, 2017).
- Abortion is still **stigmatized** to the extent that even when legal abortion services are available, women often face humiliation and judgement when requesting an abortion (Bhekisisa Mail and Guardian Centre for Health Journalism, 2018). This is further complicated by a large number of health care providers who pose opposition to abortion and struggle to separate their personal beliefs from the service that they should provide (Bhekisisa Mail & Guardian Centre for Health Journalism, 2018; Skosana, 2014).
- There is a **gap in the literature** on how South African women experience induced abortion and the strategies they use to cope. Furthermore, the extent to which abortion counselling specifically emphasizes or uses the proactive, self-regulatory, agency-related aspects of coping is unknown. Most psychological interventions for induced abortion (compare Curley, 2010; Upadhyay et al., 2010) either seem to be without a dedicated coping focus or are more reactive in nature.

The aim of the study was therefore to explore how young adult South African women experience and cope with induced abortion. The specific aims were to (i) determine what

international and South African literature is available on how young adult women experience and cope with induced abortion and to determine to what extent their coping strategies reflect self-regulation and a sense of agency and; (ii) explore how a sample of young adult South African women who had undergone an induced abortion perceive the relationship between different aspects of their experience and coping, and to develop a conceptual model based on that; and finally, (iii) to conceptualize and provide a first step toward the development of counselling guidelines to facilitate effective coping in young women who have decided to undergo an induced abortion.

In the next section, each of the three articles presented in Chapters 2, 3 and 4 are briefly summarized and interpreted within the context of the larger study. The conclusion and recommendations are presented thereafter.

Chapter 2 / Manuscript 1

The aim of Chapter 2 (Lyon & Botha, 2018) was to determine what international and South African literature is available on how young adult women experience and cope with induced abortion and to determine to what extent their coping strategies reflect a sense of agency and self-regulation. A rapid review of current international and national literature on the experience of abortion and the ways of coping with the experience of abortion was conducted by using The National Institute for Health and Clinical Excellence's (NICE) (2012) guidelines as a basic framework. The North-West University's (NWU) One Search portal with access to 262 electronic databases was used in consultation with a librarian to do a keyword search in combination with appropriate Boolean operators. Quality assessment tools for both quantitative and qualitative studies (NICE, 2012) were used to critically appraise the quality of possible articles and this yielded 11 studies for final inclusion. A narrative synthesis (Popay et al., 2006) was conducted to synthesize the findings across the 11 articles.

Five themes were identified, namely premorbid factors, stressors, negative emotions, coping strategies and positive experiences. The experience of abortion is often negatively affected by *premorbid* socio-economic challenges like poverty and partner violence. The review also revealed that abortion is strongly associated with a number of challenging *stressors*, including social stressors like perceived lack of support, stigma and internal stressors like ambivalence, conflict and lack of autonomy. Most women experience *negative emotions*, namely depression, anxiety, physical and emotional pain, and guilt, and *cope* firstly by means of self-reflection, including justification of their decision to abort, self-criticism and sense-making, and second, with avoidance behaviour like suppression and avoidance of social engagement. Lastly, most women involved in the studies experienced some *positive emotions*, mainly in the form of relief after the abortion.

The following key issues were highlighted in the discussion:

- Premorbid socio-economic challenges are especially important in the South African context as a lack of financial resources and social support (Ndwambi & Govender, 2015; Sullivan, et al., 2017; Torriente, Joubert & Steinberg, 2016) are often indicated as the primary reasons for having an abortion. In abortion counselling, this should be emphasized.
- Although there was strong evidence for the experience of negative emotions, some contradictions or inconsistencies were also noted regarding the actual aetiology, which begs the question: *To what extent is the experience of negative emotions directly linked to the unwanted pregnancy and the abortion itself? More specifically, to what extent is specifically guilt, but also other negative emotions the result of the abortion itself or due to contextual factors such as stigma?* This is also questioned in the literature, for example Boersma, Van den Berg, Van Lunsen and Laan (2014) Foster, Steinberg, Roberts, and Neuhaus (2015) as well as Gomez

(2018), and the National Collaborating Centre for Mental Health (NCCMH) (2011).

- The lack of problem-solving and emotion-focused coping other than avoidance is not adequately explained in any of the review studies, but may be explained by Benyamini's (2009) suggestion that problem-solving coping fits controllable situations and emotion-focused coping fits uncontrollable situations. This should therefore be further explored within abortion contexts.
- Some evidence, although not strong, emerged that psychological growth is possible in the form of a sense of relief and autonomy despite the challenges young women face. This is supported by a few other studies (Kero, Högberg & Lalos, 2004; Quinley, Ratcliffe & Schreiber, 2014) and should receive more attention, specifically with respect to how counsellors could facilitate strengths and broaden resources in young women.

The article concluded that abortion is a complex emotional event and an experience that should be understood contextually as it is intertwined with each woman's context, pre-abortion mental health and the unwanted pregnancy. In the South African context, it is clear that socio-economic disadvantage and premorbid relationships are important factors that should be better understood and managed. Stigma seems to be a very important factor and raises the question whether negative experiences are related to factors like stigma, the abortion itself, or even their coping efforts, for example by women isolating themselves? Psychological growth after having an abortion further seems a possibility, but not a given, and will be affected by the abortion context.

Chapter 3 / Manuscript 2:

Chapter 3 (Lyon, Botha & Preston, 2018a) aimed to explore how a sample of adult South African women who had undergone an induced abortion perceived the relationship

between different aspects of the experience and coping in their own situation. The article then developed a conceptual, hypothetical model of the relationship between the different aspects of women's abortion experience and coping. The theoretical point of departure for this study was the view that the experience of abortion, associated stressors and coping efforts are dynamically and systemically related, and that by taking this perspective, one would be able to understand the underlying self-regulation processes.

Interactive Qualitative Analysis (IQA) (Northcutt & McCoy, 2004), which aims to determine how participants' mental model of a specific reality is structured in terms of a predetermined cause-and-effect relationship, was implemented. An availability sample of 37 adult South African women between the ages of 18 and 35 years from different races and cultures, from both rural and urban backgrounds who have experienced legal induced abortion at the Reproductive Health Clinic at the Potchefstroom Hospital, North West province took part in the study. This specific phase of the study was approved by the Health Research Ethics Committee of the NWU, and the Health Department of South Africa, and was registered on the National Health Research Database.

In Phase 1 of the IQA, based on in-depth interviews with six of the participants, 13 themes emerged. The findings show that the participants experience abortion as a challenging process on both intra- and interpersonal levels. The most common and most intensely experienced were a range of negative emotions, social isolation and some cases, rejection. Coping efforts seem to be more inward-focusing, while a sense of relief emerged as the only positive consequence of the abortion. The findings to a large extent supported the findings of the rapid review (Chapter 2) by Lyon and Botha (2018). In Phase 2 of the IQA, 32 participants completed a questionnaire based on the 13 themes to develop a hypothetical model that shows how participants perceive the cause-effect relationships between the 13 themes. The model shows that the unwanted pregnancy and abortion cause a discrepancy

between important life goals and their current situation, causing them to eventually feel sad or depressed. From a self-regulation perspective, Brandtstädter and Rothermund (2002) indicate that a discrepancy motivates the individual to make changes, either in terms of their goals (accommodation), in terms of their behaviour (assimilation) or sometimes in terms of both. The women in this study mostly assimilated, in other words they still wanted to achieve their life goals, but they changed their behaviour primarily to avoid others and to protect themselves from rejection and judgement. Feeling sad or depressed results in two feedback loops, and even though there is evidence of meaning-focused coping through religious coping in the form of prayer and self-reflection, both feeds back into the challenges the women encounter without any clear healthy or positive outcomes. It was therefore suggested that the women are still in the process of coping with the abortion, and that something more constructive should be facilitated within these women to ensure psychological adjustment and growth in the long run.

Chapter 4 / Manuscript 3

The aim of the third and final article (Lyon, Botha & Preston, 2018b) was to provide a starting point in developing guidelines to facilitate effective coping in young adult women undergoing an induced abortion, based on the findings of Chapter 2 (Lyon & Botha, 2018) and Chapter 3 (Lyon, et al., 2018a). The intention was to develop the guidelines specifically for South African public hospitals, as this is where abortion counselling, due to many limitations, is currently not effectively delivered. A guideline-development approach (Gagliardi, Marshall, Huckson, James & Moore, 2015; Wight, Wimbush, Jepson & Doi, 2015), supported by aspects of intervention development (Bartholomew Eldredge et al, 2016; Craig, et al., 2008; Fraser & Galinsky, 2010), was followed. Based on the first four steps recommended by Wight et al. (2015) in the development of quality interventions, the following emerged:

The “problem” the guidelines would need to address was defined as follows: *“Abortion is a complex experience, intertwined with the difficulty of the decision not to continue with an unwanted pregnancy, further complicated by social stigma, and specifically in a country like South Africa, a lack of financial resources, partner violence, and absence of proper abortion counselling services. These factors challenge women’s self-regulatory coping efforts to such an extent that psychological growth seems to be limited if appropriate strengths within these women are not properly facilitated”*.

Based on this, it was argued that the guidelines should consider the awareness of and sensitivity to context. However, it should focus on facilitating those aspects that would decrease the discrepancy women experience in a constructive, preventive and promotive way.

The key target areas in counselling should therefore be (i) contextual factors, including background, culture, exposure to interpersonal violence, socio-economic status and perceived social stigma; (ii) internal experiences and perceptions of the client, including their emotional responses and coping skills; and finally (iii) the internal values and perceptions of the counsellor, including their own ideas and biases, and their understanding of women’s response to the abortion. These three aspects also served as the three key change mechanisms in the guidelines.

Based on young women’s experience of loss of security in their social relationships, either through stigma, unhelpful nursing staff or an absent partner, and the fact that they find it difficult to facilitate their own strengths to be able to grow from the experience, it was suggested that a combined person-centred and strengths approach should be incorporated in the development of the guidelines.

Next, a 2x3 conceptual grid was compiled as a framework for the counselling guidelines, to ensure that each of three change mechanisms could be implemented according to the two theoretical approaches. In summary, it was recommended that:

- Counsellors should recognize and put their own preconceived ideas about abortion aside and be clear about their own values. They should further not assume the presence of psychopathology in the women, but rather provide them with the information, skills, support and confidence to broaden their resources and improve their sense of agency and wellbeing.
- Counsellors should sensitively and supportively consider the context of the unwanted pregnancy and the abortion, such as stigma, poverty and partner violence, and recognize clients' ability to be resilient despite contextual challenges.
- Counsellors should understand the role negative emotions play in adverse situations and non-judgmentally allow them to express their negative emotions, frustrations, and difficulties. They should then facilitate pro-active and problem-focused coping skills as well as meaningful and attainable new approach goals to ensure resilience in the long run. They should guide the women to identify and activate social support as a general resource, and finally, guide young women on how to flexibly apply different coping skills to create a sense of autonomy and agency.

Finally, the guidelines were developed to be implemented within the context of South African public hospitals, by health workers currently involved in abortion counselling but with proper training by a psychologist or psychological counsellor. The guidelines are specifically intended for women who have already decided to undergo a legal induced abortion or have already experienced it, and meant for counsellors to flexibly integrate with their current procedures and not to replace the standard pre- and post-abortion counselling, specifically regarding the medical aspects of the abortion.

Limitations

This study had a number of limitations that should be taken into consideration before conclusion can be drawn. Manuscript 1 (Lyon & Botha, 2018) applied a rapid review. The review had several limitations, namely: (i) only articles written in English were included; therefore important knowledge documented in other languages that could have contributed to this study might have been missed; (ii) relatively few studies (n=11) were included and caution should therefore be exercised when drawing conclusions about the experience of abortion in general; (iii) some older studies were included, and their findings should be interpreted with the consideration of the fact that the social context has changed considerably, especially with respect to attitude about and service delivery regarding abortion; (iv) certain studies meeting the inclusion criteria may have been overlooked; (v) the studies were quite heterogeneous, which makes it difficult to compare or integrate themes from different contexts or to generalize the findings to a South African context; (vi) studies were generally not well controlled for the influence of external factors on the abortion experience; (vii) only some aspects related to personality and social background were indicated, creating uncertainty about the role other external factors might play; and finally, (viii) almost nothing emerged regarding coping as a self-regulatory process. As such, conclusions should carefully be drawn. However, it also highlights the lack of data in this regard and points towards a gap in research that should be addressed.

Manuscript 2 (Lyon, et al., 2018a) focused on one specific context only, namely the Reproductive Health Clinic at the Potchefstroom Hospital. In addition, the participants were fairly homogenous, and only six were available for the first-round interviews compared to the recommendation of between 8 and 16 by Northcutt and McCoy (2004). The aim was however to develop a hypothetical model and not to test a specific hypothesis with a large random number of participants. Secondly, due to the sensitive ethical factors involved in this study, it

was not possible to conduct the interviews within a focus group context as is usually done in IQA. To ensure trustworthiness, the authors followed the IQA guidelines very strictly and critically reflected on any possible biases during the data analysis phase. These limitations are therefore not seen as significant, especially as the study attempted to explore rather than to determine.

Manuscript 3 (Lyon, et al., 2018b) did not evaluate the guidelines. We therefore do not know how effective they are. The aim was however to provide a starting point for the development of counselling guidelines without evaluating it as well. A number of issues may influence an evaluation of guideline implementation; therefore, the contribution should rather be seen as a first step based on research evidence. Another possible limitation is the fact that the guidelines are primarily based on the context of an abortion experience in a South African public hospital. Therefore, even though the guidelines are not rigid, it may not be generalizable to other contexts. The idea was however not to claim either effectiveness or generalizability, as these aspects were outside the scope of the current study.

Integrated conclusion

In summary, it is clear that an unwanted pregnancy and abortion is a complex, intertwined experience. Each woman is uniquely acquainted with her abortion decision, experience and aftermath, mainly because the experience and coping efforts are greatly influenced by each women's context and pre-abortion mental health. Abortion is experienced as a challenging process, which affects both inter- and intra-personal relationships. Women often experience a lack of support, negative emotions, isolation or rejection during the abortion process, while evidence of positive experiences was not highly visible.

In terms of coping, self-regulation and agency, the following can be concluded: An unwanted pregnancy seems to be the starting point of an event that causes a discrepancy between important future life goals (where I want to be) and current context (where I am).

From a self-regulation perspective, being aware of a discrepancy motivates the women to make changes which, as is evident from chapter 2, (Lyon & Botha, 2018) appears to be primarily assimilative (compare Brandtstädter & Rothermund, 2002). In other words, they still want to achieve their life goals, but they change their behaviour in terms of avoiding others and in doing so, perhaps protecting themselves from rejection and judgement. The resulting lack of social support and absence of clear problem-focused coping efforts, contribute to maintenance (for now) of their negative experiences. In order to facilitate psychological growth trajectories (Fredrickson, 2013) in these women, their resources (e.g. relief, prayer, sense of autonomy) should be fostered and broadened. In addition, they need to learn more proactive coping skills, as well as the flexible interchange between assimilation and accommodation (changing of and setting new life goals).

Counsellors could play an important role to change the perceived stigma, lack of social support and experience of feelings of guilt. The guidelines that were developed therefore emphasize consideration of each woman's context when providing counselling. It further recommends a combined person-centred and strengths approach to maximise the effectiveness of three crucial change mechanisms.

Contribution of the study

This study's main contribution is that it offers new insights regarding the experience of and coping with abortion in adult women from a self-regulatory perspective in a South African context. It is the first study that explored abortion-related coping from a self-regulation perspective. It is unique in its contribution of an IQA-based hypothetical model that sheds new light on how the abortion experience and coping efforts may unfold over time. It emphasizes the complexity of abortion, intertwined with the unwanted pregnancy, social context, emotion, and degree of ability to flexibly cope with a number of challenges. The importance of proactive coping is implicitly underlined in the findings of both Chapters 2 and

3 because it should provide women with more options to anticipate and create a better future, and as such, a stronger sense of agency. In this regard, the words of Erica Frydenberg (2017, p. 217) are highly applicable: “Coping is a positive psychological tool, consistent with the developments in positive psychology, with its emphasis on what people can do rather than what they can’t do...”.

The study further contributes to the debate on abortion and mental health by showing that the sample of South African women, as in international literature, have resources but are limited to meaning-focused and avoidance-coping efforts. Although these efforts provide some resilience, it may not be enough to prevent them from being vulnerable to developing mental health related difficulties in the long run if effective counselling is not provided.

Furthermore, this study provides intervention guidelines to give health care professionals in South African public hospital settings insight into how counselling could promote the health of women who experience abortion, and especially, how to apply such counselling in the most effective way possible. The guidelines were based on two empirical studies and produced a structured, yet flexible 2x3 grid conceptualization that structures and integrates a proposed theoretical approach with three change mechanisms. The hope is that the guidelines would contribute to a more critical discourse, further research and eventually the successful implementation of more structured abortion counselling guidelines. Lastly, this study contributes by laying a foundation for future researchers to build on.

Recommendations for further research

Further research is recommended to better understand some of the dynamics that emerged from this study, for example the extent to which stigma, avoidance and self-reflection are related and if and why problem-solving focused coping is generally lacking among women during the abortion process; as well as factors that facilitate psychological growth over the long term in women post-abortion. In addition, further research should

explore the experience of and coping with abortion in different and more heterogenic contexts. Since a broad approach was taken to self-regulation in this study, future research could benefit from applying specific self-regulation models or theories, more specifically the ‘what’ and ‘how’ of emotion regulation in response to abortion as this did not clearly emerge from the findings of this study. Also, research should be done to confirm the extent to which the IQA model would hold true statistically, for example, through structural equation modelling within large random samples.

Further research on the evaluation of the developed guidelines is also recommended to determine their effectiveness. One possible limitation in the guidelines developed in this study is exactly how premorbid socio-economic factors should effectively be integrated in abortion counselling, future research needs to provide more answers in this respect. In addition, more tailor-made counselling guidelines for the different cultures in South Africa should be explored. Finally, more should be done to convert what we know about coping with abortion into current abortion counselling programmes in South African clinics and hospitals.

References

- Bartholomew Eldredge, L., Markham, C., Ruiter, R., Fernandez, M., Kok, G., & Parcel, G. (2016). *Planning Health Promotion Programs. An Intervention Mapping Approach* (4th ed.). ProQuest Ebook Central: John Wiley & Sons.
- Benyamini, Y. (2009). Stress and coping with women's health issues. A review from a self-regulation perspective. *European Psychologist, 14*(1), 63-71.
- Bhekisisa Mail and Guardian Centre for Health Journalism. (2018, June 18). *Sexual and reproductive justice coalition*. Retrieved from http://srjc.org.za/wp-content/uploads/2018/06/i8jNT5fVReGoh4Uray3r_Bhekisisa_SafeAbortion_final_2018.pdf
- Bhekisisa. (2017, November 20). *#SizaMap: Find a safe, legal abortion near you with this list of designated providers*. Retrieved from <http://bhekisisa.org/article/2017-11-20-sizamap-find-a-safe-legal-abortion-near-you-with-this-list-of-designated-providers-1>
- Boersma, A. A., Van den Berg, D., Van Lunsen, R. H., & Laan, E. T. (2014). Induced abortion is not associated with a higher likelihood of depression in Curaçao women. *The European Journal of Contraception and Reproductive Health Care, 19*, 359-367.
- Brandtstädter, J., & Rothermund, K. (2002). The life-course dynamics of goal pursuit and goal adjustment: A two-process framework. *Developmental Review, 22*(1), 117-150.
- Curley, M. (2010). Psychological distress after abortion among university students: Developing an intervention (Vol. 72). Montreal: ProQuest Information & Learning.
- Foster, D. G., Steinberg, J. R., Roberts, S. C., & Neuhaus, J. (2015). A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychological Medicine, 45*(10), 2073-2082.

- Fraser, M. W., & Galinsky, M. J. (2010). Steps in Intervention Research: Designing and Developing Social Programs. *Research on Social Work Practice, 20*(5), 459-466.
- Fredrickson, B.L. (2013) Updated thinking on positivity ratios. *American Psychologist, 68*(9), 814-822.
- Frydenberg, E. (2014). Coping research: Historical background, links with emotion, and new research directions on adaptive processes. *Australian Journal of Psychology, 66*, 82-92.
- Gagliardi, A.R., Marshall, C., Huckson, S., James, R., & Moor, V. (2015). Developing a checklist for guideline implementation planning: review and synthesis of guideline development and implementation advice. *Implementation Science, 10*(19), 1-9.
- Gomez, A. M. (2018). Abortion and subsequent depressive symptoms: an analysis of the National Longitudinal Study of Adolescent Health. *Psychological Medicine, 48*(2), 294-304.
- Kero, A., Högberg, U., & Lalos, A. (2004). Wellbeing and mental growth - long-term effects of legal abortion. *Social Science and Medicine, 58*(12), 2559-2569.
- Lyon, R., & Botha, K.F.H. (2018) The Experience of and Coping with Abortion: A Rapid Review. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 2). Unpublished doctoral thesis. North-West University, Potchefstroom.

- Lyon, R., Botha, K.F.H., & Preston, L.D. (2018a). The experience and coping strategies of a group of South African women who had an induced abortion. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 3). Unpublished doctoral thesis. North-West University, Potchefstroom.
- Lyon, R., Botha, K.F.H., & Preston, L.D. (2018b). Towards the development of guidelines to facilitate effective coping in young adult women undergoing induced abortion. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 4). Unpublished doctoral thesis. North-West University, Potchefstroom.
- Moore, J., & Ellis, E. (2013, January 21). *In South Africa, A liberal abortion law doesn't guarantee access*. Retrieved from <https://www.thenation.com/article/south-africa-liberal-abortion-law-doesnt-guarantee-access/>
- National Institute for Health and Clinical Excellence (NICE). (2012). *Methods for the development of NICE public health guidance*. Retrieved from <http://www.nice.org.uk/about>
- Ndwambi, A., & Govender, I. (2015). Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal South Africa. *Southern African Journal of Infectious Diseases*, 30(4), 129–133.
- Northcutt, N., & McCoy, D. (2004). *Interactive qualitative analysis. A systems method for qualitative research*. London: Sage.

- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme*. Retrieved from http://www.lancaster.ac.uk/shm/research/nssr/research/dissemination/publications/NS_Synthesis_Guidance_v1.pdf
- Quinley, K. E., Ratcliffe, S. J., & Schreiber, C. A. (2014). Psychological coping in the immediate post-abortion period. *Journal of Women's Health, 23*(1).
- Skosana, I. (2014, September 26). Abortion turns into a nightmare. *Mail and Guardian Africa's Best Read*. Retrieved from <http://mg.co.za/article/2014-09-26-abortion-turns-into-a-nightmare>
- Sullivan, M. E., Harrison, A., Harries, J., Sicwebu, N., Rosen, R. K., & Galarraga, O. (2017). Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study. *Health Care for Women International*. doi:10.1080/07399332.2017.1400034
- Torriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, South Africa. *African Journal of Nursing and Midwifery, 119–131*.
- Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010). Informing abortion counselling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Education and Counselling, 81*, 415–421.

Vincent, L. (2012). Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order - a view from South Africa. *Culture, Health and Sexuality*, 14(2), 125-138.

Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2016). Six steps in quality intervention development. *Journal of Epidemiological Community Health*, 70(5), 520-525.

Combined Reference List

- Aantjes, C. J., Gilmoor, A., Syurina, E. V., & Crankshaw, T. L. (2018). The status of provision of post abortion care services for women and girls in Eastern and Southern Africa: a systematic review. *Contraception, 98*, 77–88.
- Aldwin, C. M., Skinner, E. A., Zimmer-Gembeck, M. J., & Taylor, A. (2011). Coping and self-regulation across the life span. In K. L. Fingerman, C. A. Berg, J. Smith, & T. C. Antonucci, *Handbook of life-span development* (pp. 561–587). New York: Springer Publishing Co.
- American College of Pediatricians. (2018). Induced abortion: Risks that may impact adolescents, young adults, and their children. *Issues in Law and Medicine, 33*(1), 85-112.
- American Psychological Association (APA) Task force on mental health and abortion. (2008). *Report of the APA task force on mental health and abortion*. Retrieved from <https://www.apa.org/pi/women/programs/abortion/mental-health.pdf>
- American Public Health Association. (2015, November 3). *Restricted access to abortion violates human rights, precludes reproductive justice, and demands public health intervention*. Retrieved from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights>
- Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: self-regulation and proactive coping. *Psychological Bulletin, 121*(3), 417–436.

- Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, 52, 1–26.
- Bandura, A. (2008). The reconstrual of "free will" from the agentic perspective of social cognitive theory. In J. Baer, J. C. Kaufman, & R. F. Baumeister, *Are we free? Psychology and free will* (pp. 86–127). Oxford: Oxford University Press.
- Bandura, A. (2018). Toward a psychology of human agency: Pathways and reflections. *Association for Psychological Science*, 13(2), 130–136.
- Bargate, K. (2014). Interactive qualitative analysis - a novel methodology for qualitative research. *Mediterranean Journal of Social Sciences*, 5(20), 11–19.
- Bartholomew Eldredge, L., Markham, C., Ruiter, R., Fernandez, M., Kok, G., & Parcel, G. (2016). *Planning health promotion programs. An intervention mapping approach* (4th ed.). ProQuest Ebook Central: John Wiley & Sons.
- Baumann, N., Kaschel, R., & Kuhl, J. (2005). Striving for unwanted goals: Stress-dependent discrepancies between explicit and implicit achievement motives reduce subjective well-being and increase psychosomatic symptoms. *Journal of Personality and Social Psychology*, 89, 781-799.
- Baumgardner, S., & Crothers, M. (2010). *Positive psychology*. Upper Saddle River: Pearson.
- Benyamini, Y. (2009). Stress and coping with women's health issues. A review from a self-regulation perspective. *European Psychologist*, 14(1), 63-71.
- Berger, A. (2011). *Self-regulation: Brain, cognition and development*. Washington DC: American Psychological Association.

- Beynon-Jones, S. M. (2017). Untroubling abortion: A discourse analysis of women's accounts. *Feminism & Psychology, 27*, 225–242.
- Bhekisisa Mail and Guardian Centre for Health Journalism. (2018, June 18). *Sexual and reproductive justice coalition*. Retrieved from http://srjc.org.za/wp-content/uploads/2018/06/i8jNT5fVReGoh4Uray3r_Bhekisisa_SafeAbortion_final_2018.pdf
- Bhekisisa. (2017, November 20). *#SizaMap: Find a safe, legal abortion near you with this list of designated providers*. Retrieved from <http://bhekisisa.org/article/2017-11-20-sizamap-find-a-safe-legal-abortion-near-you-with-this-list-of-designated-providers-1>
- Billings, A. G., & Moos, R. H. (1981). The role of coping responses and social resources in attenuating the impact of stressful life events. *Journal of Behavioral Medicine, 4*, 139-157.
- Birdsey, G., Crankshaw, T. L., Mould, S., & Ramklass, S. S. (2016). Unmet counselling need amongst women accessing an induced abortion service in Kwazulu-Natal, South Africa. *Contraception, 94*, 473–477.
- Biswas-Diener, R., Kashdan, T., & Minhas, G. (2011). A dynamic approach to psychological strength development and intervention. *The Journal of Positive Psychology, 6*(2), 106-118.
- Boersma, A. A., Van den Berg, D., Van Lunsen, R. H., & Laan, E. T. (2014). Induced abortion is not associated with a higher likelihood of depression in Curaçao women. *The European Journal of Contraception and Reproductive Health Care, 19*, 359-367.

- Boulind, M., & Edwards, D. (2008). The assessment and treatment of post-abortion syndrome: A systematic case study from South Africa. *Journal of Psychology in Africa, 18*(4), 539–548.
- Brandtstädter, J., & Rothermund, K. (2002). The life-course dynamics of goal pursuit and goal adjustment: A two-process framework. *Developmental Review, 22*(1), 117–150.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy*. Thousand Oaks, CA: Sage.
- Cameron, S. (2010). Induced abortion and psychological sequelae. Best practice and research. *Clinical Obstetrics and Gynaecology, 24*, 657–665.
- Carver, C. S. (1979). A cybernetic model of self-attention processes. *Journal of Personality, 37*, 1251–1281.
- Carver, C. S., & Scheier, M. F. (1998). *On the self-regulation of behavior*. New York, NY: Cambridge University Press.
- Carver, C. S., & Scheier, M. F. (2013). Goals and emotion. In M. D. Robinson, E. R. Watkins, & E. Harmon-Jones, *Handbook of cognition and emotion* (pp. 176–194). New York, NY: The Guilford Press.
- Carver, C. S., & Scheier, M. F. (2016). Self-regulation of action and affect. In K. D. Vohs, & R. F. Baumeister, *Handbook of self-regulation: Research, theory and applications* (3rd ed., pp. 3–23). Guilford Press.

- Carver, C. S., & Scheier, M. F. (2017). Self-regulatory functions supporting motivated action. In A. J. Elliot, *Advances in motivational science* (3rd ed., vol. 4, pp. 1–37). Cambridge, MA: Elsevier.
- Carver, C. S., Scheier, M. F., & Fulford, D. (2008). Self-regulatory processes, stress and coping. In O. John, R. Robins, & L. Pervin, *Handbook of personality. Theory and research*. (3rd ed., pp. 725-742). New York: Guilford Press.
- Charles, V. E., Polis, C. B., Shridhara, S. K., & Blum, R. W. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception*, 78(6), 436–450.
- Choice on Termination of Pregnancy Act 92 of 1996 **see** South Africa. (1996).
- Choice on Termination of Pregnancy Amendment Act 1 of 2008 **see** South Africa. (2008).
- Cleary, T. J., Callan, G. L., & Zimmerman, B. J. (2012). Assessing self-regulation as cyclical, context-specific phenomenon: overview and analysis of SRL microanalytic protocols. *Education Research International*. doi:10.1155/2012/428639
- Cockrill, K., & Nack, A. (2013). 'I'm not that type of person'. Managing the stigma of having an abortion. *Deviant Behaviour*, 34(12), 973–990.
- Cooper, D., Dickson, K., Blanchard, K., Cullingworth, L., Mavimbela, N., Von Mollendorf, C., Winikoff, B. (2005). Medical abortion: the possibilities for induction in public sector South Africa. *Reproductive Health Matters*, 13(26), 35–43.
- Cooper, D., Harries, J., Moodley, J., Constant, D., Hodes, R., Mathews, C., Hoffman, M. (2016). Coming of age? Women's sexual and reproductive health after twenty-one years of democracy in South Africa. *Reproductive Health Matters*, 24(48), 79–89.

- Cooper, M. L., Wood, P. K., Orcutt, H. K., & Albino, A. (2003). Personality and the predisposition to engage in risky or problem behaviors during adolescence. *Journal of Personality and Social Psychology, 84*, 390–410.
- Costa, F., Jessor, R., & Donovan, J. E. (1987). Psychosocial correlates and antecedents of abortion: An exploratory study. *Population and Environment, 9*(1), 3-22.
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new medical research council guidance. *BMJ Journal, 979-983*.
- Curley, M. (2010). Psychological distress after abortion among university students: Developing an intervention (Vol. 72). Montreal: ProQuest Information & Learning.
- Curley, M., & Johnston, C. (2013). The characteristics and severity of psychological distress after abortion among university students. *Journal of Behavioral Health Services and Research, 40*(3), 279.
- De Ridder, T. D., & Kuijer, R. G. (2006). Managing immediate needs in the pursuit of health goals: The role of coping in self-regulation. In D. De Ridder, & J. De Wit, *Self-regulation in health behavior* (pp. 147-168). Chichester: John Wiley.
- Diehl, M., Semegon, A. B., & Schwarzer, R. (2006). Assessing attention control in goal pursuit: A component of dispositional self-regulation. *Journal of Personality Assessment, 86*, 306-317.
- Drummond, S., & Brough, P. (2016). Proactive coping and preventive coping: Evidence for two distinct constructs? *Personality and Individual Differences, 92*, 123–127.

- Dykes, K., Slade, P., & Haywood, A. (2011). Long term follow-up of emotional experiences after termination of pregnancy: women's views at menopause. *Journal of Reproductive and Infant Psychology, 29*(1), 93-112.
- Ely, E. (2007). The abortion counselling experience: A discussion of patient narratives and recommendations for best practices. *Best Practices in Mental Health, 3*(2).
- Evidence for Policy and Practice Information and Co-ordinating Centre. (2007). *EPPI-Centre methods for conducting systematic reviews*. London: Social Science Research Unit, Institute of Education, University of London.
- Fergusson, D. M., Horwood, L., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47*(1), 16–24.
- Fingerer, M. E. (1973). Psychological sequelae of abortion: Anxiety and depression. *Journal of Community Psychology, 1*(2), 221–225.
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology, 55*, 745–774.
- Forgas, J. (2013). Don't worry, be sad! On the cognitive motivational and interpersonal benefits of negative mood. *Current Directions in Psychological Science, 22*.
- Foster, D. G., Gould, H., Taylor, J., & Weitz, T. A. (2012). Attitudes and decision making among women seeking abortions at one U.S. clinic. *Perspectives on Sexual and Reproductive Health, 44*(2), 117–124.
- Foster, D. G., Steinberg, J. R., Roberts, S. C., & Neuhaus, J. (2015). A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychological Medicine, 45*(10), 2073-2082.

- Fraser, M. W., & Galinsky, M. J. (2010). Steps in intervention research: Designing and developing social programs. *Research on Social Work Practice, 20*(5), 459-466.
- Fredrickson, B.L. (2013). Updated thinking on positivity ratios. *American Psychologist, 68*(9), 814-822.
- Frydenberg, E. (2014). Coping research: Historical background, links with emotion, and new research directions on adaptive processes. *Australian Journal of Psychology, 66*, 82-92.
- Frydenberg, E. (2017). Concluding thoughts. In E. Frydenberg. *Coping and the Challenge of Resilience*. (pp. 217-220). London: Palgrave.
- Frydenberg, E. (2017). Spiritual approaches to coping and mindfulness. In E. Frydenberg. *Coping and the challenge of resilience*. (pp. 175-192). London: Palgrave.
- Furnham, A., Ritchie, W., & Alixe, L. (2016). Beliefs about the causes and cures of depression. *International Journal of Social Psychiatry, 62*(5), 415–424.
- Gagliardi, A.R., Marshall, C., Huckson, S., James, R., & Moor, V. (2015). Developing a checklist for guideline implementation planning: review and synthesis of guideline development and implementation advice. *Implementation Science, 10*(19), 1-9.
- Ganann, R., Ciliska, D., & Thomas, H. (2010). Expediting systematic reviews: methods and implications of rapid reviews. *Implementation Science, 5*(5). doi: 10.1186/1748-5908-5-56
- Gobindji, R., & Linley, A. (2007). Strengths use, self-concordance and well-being: Implications for strengths coaching and coaching psychologists. *International Coaching Psychology Review, 2*, 143-153.

- Gomez, A. M. (2018). Abortion and subsequent depressive symptoms: an analysis of the national longitudinal study of adolescent health. *Psychological Medicine, 48*(2), 294-304.
- Grant, A., Franklin, J., & Langford, P. (2002). The self-reflection and insight scale: A new measure of private self-consciousness. *Social Behavior and Personality: An International Journal, 30*, 821-836.
- Gray, J. B. (2015). "It has been a long journey from first knowing": Narratives of unplanned pregnancy. *Journal of Health Communication, 20*(6), 736-742.
- Greenglass, E. R. (2002). Proactive coping. In E. Frydenberg, *Beyond coping: Meeting goals, vision and challenges* (pp. 37-62). London: Oxford University Press.
- Grivas, J. (2006). *Oxford psychology study dictionary* (2nd ed.). Oxford: Oxford University Press.
- Guse, T. (2014). Activities and programmes to enhance well-being. In M. Wissing, J. Potgieter, T. Guse, T. Khumalo, & I. Nel, *Towards flourishing: Contextualising positive psychology* (pp. 291-314). Pretoria: van Schaik.
- Hagenaars, M. A., Fisch, I., & Van Minnen, A. (2011). The effect of trauma onset and frequency on PTSD-associated symptoms. *Journal of Affective Disorders, 132*, 192-199.
- Halldén, B., Christensson, K., & Olsson, P. (2008). Early abortion as narrated by young Swedish women. *Scandinavian Journal of Caring Sciences, 23*(2), 243-250.
- Halldén, B., Christensson, K., & Olsson, P. (2009). Early abortion as narrated by young Swedish women. *Scandinavian Journal of Caring Sciences, 23*(2), 243-250.

- Hanschmidt, F., Linde, K., Hillbert, A., Riedel-Heller, S. G., & Kersting, A. (2016). Abortion stigma: A systematic review. *Perspectives on Sexual and Reproductive Health, 48*(4), 169–177.
- Harden, A., & Ogden, J. (1999). Young women's experience of arranging and having abortions. *Sociology of Health and Illness, 21*(4), 426.
- Harries, J., Cooper, D., Strebel, A., & Calvin, C. J. (2014). Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *Reproductive Health, 11*(16), 1–7.
- Healey, D., Gray, A. R., Chae, M., Taylor, B. J., Lawrence, J., Reith, D. M., & Wheeler, B. J. (2018). The role of parent and child self-regulation in children's glycemic control. *Health Psychology, 37*(4), 326–333.
- Heckhausen, J., Wrosch, C., & Schultz, R. (2010). A motivational theory of life-span development. *Psychological Review, 117*(1), 32–60.
- Hennecke, M. (2018). What doesn't kill you...: Means for avoidance goal pursuit are less enjoyable than means for approach goal pursuit. *Motivational Science*.
- Hobfoll, S. E. (2010). Conservation of resources theory: Its implication for stress, health, and resilience. *The Oxford handbook of stress, health, and coping, 127–147*.
doi:10.1093/oxfordhb/9780195375343.013.0007
- Human-Vogel, S. (2006). Students' mental models of positive mood and self-regulation in learning. *South African Journal of Psychology, 36*(3), 613–633.

- International Planned Parenthood Federation. (2010, May 2). *First trimester abortion guidelines and protocols*. Retrieved from International Planned Parenthood Federation: <https://www.ippf.org/resource/first-trimester-abortion-guidelines-and-protocols>
- Kafeel, T., Shoaib, R., Sohail, F., Yamin, F., Ahmed, I., & Paracha, H. (2018). Level of stress among doctor of physical therapy. *Indian Journal of Physiotherapy & Occupational Therapy, 12*(1), 112-117.
- Kawonga, M., Blanchard, K., Cooper, D., Cullingworth, L., Dickson, K., Harrison, T., Winikoff, B. (2008). Integrating medical abortion into safe abortion services experience from three pilot sites in South Africa. *Journal of Family Planning and Reproductive Health Care, 34*(3), 159–164.
- Kero, A., Högberg, U., & Lalos, A. (2004). Wellbeing and mental growth - long-term effects of legal abortion. *Social Science and Medicine, 58*(12), 2559-2569.
- Kilander, H., Berterö, C., Thor, J., Brynhildsen, J., & Alehagen, S. (2018). Women's experiences of contraceptive counselling in the context of an abortion - An interview study. *Sexual and Reproductive Healthcare, 17*, 103-107.
- Kimport, K., Foster, K., & Weitz, T.A. (2011). Social sources of women's emotional difficulty after abortion: lessons from a qualitative analysis of women's abortion narratives. *Perspectives on Sexual and Reproductive Health, 43*(2), 103-109.
- Knabb, J. J., & Vazquez, V. E. (2018). A randomized controlled trial of a 2-week internet-based contemplative prayer program for Christians with daily stress. *Spirituality in Clinical Practice, 5*(1), 37–53.

- Kumar, A., Hessini, L., & Mitchell, E. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality, 11*, 625–639.
- Lazarus, R. S. (1991). *Emotion and adaption*. New York, NY: Oxford University Press.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer.
- Leiner, A. S., Kearns, M. C., Jackson, J. L., Astin, M. C., & Rothbaum, B. O. (2012). Avoidant coping and treatment outcome in rape-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 80*, 317.
- Lince-Deroche, N., Fetters, T., Sinanovic, E., & Blanchard, K. (2017). Accessing medical and surgical first-trimester abortion services: women's experiences and costs from an operations research study in Kwazulu-Natal Province, South Africa. *Contraception, 96*(1), 72–80.
- Lince-Deroche, N., Pleaner, M., Harries, J., Morroni, C., Mullick, S., Firnhaber, C., Sinanovic, E. (2016). Achieving universal access to sexual and reproductive health services: the potential and pitfalls for contraceptive services in South Africa. *South African Health Review, 2016*(1), 95-108.
- Lincoln, Y. S., & Guba, E. G. (1995). *Naturalistic Inquiry*. Newbury Park: Sage.
- Little, T. D., Hawley, P. H., Henrich, C. C., & Marsland, K. W. (2002). Three views of the agentic self: A developmental synthesis. In E. L. Deci, & R. M. Ryan, *Handbook of self-determination research* (pp. 470). New York, NY: University of Rochester Press.

- Lundell, I. W., Öhman, S. G., Frans, Ö., Helström, L., Högberg, U., Nyberg, S., Svanberg, A. S. (2013). Posttraumatic stress among women after induced abortion: a Swedish multi-centre cohort study. *BMC Women's Health*, *13*(1), 1–21.
- Lyon, R., & Botha, K.F.H. (2018) The experience of and coping with abortion: A rapid review. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 2). Unpublished doctoral thesis. North-West University, Potchefstroom.
- Lyon, R., Botha, K.F.H., & Preston, L.D. (2018a). The experience and coping strategies of a group of South African women who had an induced abortion. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 3). Unpublished doctoral thesis. North-West University, Potchefstroom.
- Lyon, R., Botha, K.F.H., & Preston, L.D. (2018b). Towards the development of guidelines to facilitate effective coping in young adult women undergoing induced abortion. In R. Lyon. 2018. *The nature and dynamics of coping with induced abortion in young adult women*. (Chapter 4). Unpublished doctoral thesis. North-West University, Potchefstroom.
- Madiba, S., & Nekhumbe, T. (2014). Life circumstances and reasons that compel women to seek termination of pregnancy in Vhembe district. *African Journal for Physical, Health Education, Recreation and Dance*, *1*(1), 58–73.
- Maes, S., & Karoly, P. (2005). Self-regulation and intervention in physical health and illness: a review. *Applied Psychology: An International Review*, *54*(2), 267–299.

- Major, B., & Schmader, T. (2001). Legitimacy and the construal of social disadvantage. In J. T. Jost, & B. Major, *The psychology of legitimacy: Emerging perspectives on ideology, justice, and intergroup relations* (p. 176). Cambridge: Cambridge University Press.
- Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health. *American Psychologist*, *64*(9), 863–890.
- Major, B., Cozzarelli, C., Cooper, M. L., Zubek, J., Richards, C., Wilhite, M., & Gramzow, R. H. (2000). Psychological responses of women after first-trimester abortion. *Archives of General Psychiatry*, *57*(8), 777–784.
- Major, B., Richards, C., Cooper, M. L., Cozzarelli, C., & Zubek, J. (1998). Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. *Journal of Personality and Social Psychology*, *74*(3), 735-752.
- Mamabolo, L. R., & Tjallinks, J. E. (2010). Experiences of registered nurses at one community health care centre near Pretoria providing termination of pregnancy services. *Africa Journal of Nursing and Midwifery*, *12*(1), 73–86.
- Mann, T., & De Ridder, D. (2013). Self-regulation of health behavior: Social psychological approaches to goal setting and goal striving. *Health Psychology*, *32*(5), 487–498.
- Mavuso, J. M., du Toit, R., & Macleod, C. I. (2017, September). *Critical Studies in Sexualities and Reproduction Research Programme*. Retrieved from https://www.ru.ac.za/media/rhodesuniversity/content/criticalstudiesinsexualitiesandproduction/documents/20180926_PolicyBrief_PreAbortionCounselling.pdf

- Mavuso, J. M., Du Toit, R., Macleod, C. I., & Stevens, M. (2018, July 24). Retrieved from Sexual and Reproductive Justice Coalition: <https://srjc.org.za/2018/07/24/abortion-counselling-in-south-africa-a-step-by-step-guide-for-providers-2/>
- McClelland, M. M., & Cameron, C. E. (2012). Self-regulation in early childhood: Improving conceptual clarity and developing ecologically valid measures. *Child Development Perspectives*, 6, 136–142.
- Medical Research Council. (2000). *A framework for the development and evaluation of RTC's for complex interventions to improve health*. London: MRC.
- Merriam Webster. (2018, October 8). *Merriam Webster dictionary*. Retrieved from Merriam Webster: <https://www.merriam-webster.com/dictionary/context>
- Ministry of Health, Nutrition and Indigenous Medicine Sri Lanka. (2015). Retrieved from <http://www.slkog.lk/img/2017/post%20abortional%20care/National%20Guidelines%20on%20Post%20Abortion%20Care.pdf>
- Mojapelo-Batka, E. M., & Schoeman, J. B. (2003). Voluntary termination of pregnancy: Moral concerns and emotional experiences among black South African adolescents. *South African Journal of Psychology*, 33(3), 144-153.
- Monsour, K. J., & Stewart, B. (1973). Abortion and sexual behaviour in college women. *American Journal of Orthopsychiatry*, 43(5), 804–814.
- Mookamedi, R. E., Mogotlane, S. M., & Roos, J. H. (2015, November). The experience of women who undergo termination of pregnancy in Mpumalanga province, South Africa. *Africa Journal of Nursing and Midwifery*, 17, 146–161.

- Moore, J., & Ellis, E. (2013, January 21). *In South Africa, A liberal abortion law doesn't guarantee access*. Retrieved from <https://www.thenation.com/article/south-africa-liberal-abortion-law-doesnt-guarantee-access/>
- Murphy, J. M., Horton, N. J., Laird, N. M., Monson, R. R., Sobol, A. M., & Leighton, A. H. (2004). Anxiety and depression: a 40-year perspective on relationships regarding prevalence, distribution, a comorbidity. *Acta Psychiatrica Scandinavica*, *109*, 355–375.
- National Collaborating Centre for Mental Health (NCCMH). (2011, December). Induced abortion and mental health: a systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors. *Academy of Medical Royal Colleges*. Retrieved from http://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf
- National Department of Health South Africa. (2017, May). *South Africa demographic and health survey*. Retrieved from <https://www.statssa.gov.za/publications/Report%2003-00-09/Report%2003-00-092016.pdf>
- National Institute for Health and Clinical Excellence (NICE). (2012). *Methods for the development of NICE public health guidance*. Retrieved from <http://www.nice.org.uk/about>
- Ndwambi, A., & Govender, I. (2015). Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal South Africa. *Southern African Journal of Infectious Diseases*, *30*(4), 129–133.

- Ngene, N. C., Ross, A., & Moodley, J. (2013). Characteristics of women having first-trimester termination of pregnancy at a district hospital in Kwazulu-Natal. *South African Journal of Epidemiol Infect [the journal title should be written out in full]*, 28(2), 102–105.
- Norris, A., Bessett, D., Steinberg, J. R., Kavannaugh, M. L., de Zordo, S., & Becker, D. (2011). Abortion stigma: a reconceptualization of constituents, causes and consequences. *Womens Health Issues*, 21(3), 49–54.
- Northcutt, N., & McCoy, D. (2004). *Interactive qualitative analysis. A systems method for qualitative research*. London: Sage.
- Osman, S., & Thompson, A. (2012, July 2). *Unsafe abortion in South Africa: A preventable pandemic*. Retrieved from <http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic>
- Pallitto, C. C., García-Moreno, C., Jansen, H. A., Heise, L., Ellsberg, M., & Watts, C. (2012). Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence. *International Journal of Gynecology and Obstetrics*, 120(1), 3-9.
- Petersen, I. (2010). At the heart of development: an introduction to mental health promotion and the prevention of mental disorders in scarce-resource contexts. In I. Petersen, A. Bhana, A. Flisher, L. Swartz, & R. L., *Promoting mental health in scarce-resource contexts* (pp. 3-20). Cape Town: Humans Sciences research Council Press.
- Peterson, C., & Seligman, M. E. (2004). Self-regulation. In C. Peterson, & M. E. Seligman, *Character strengths and virtues. A handbook and classification* (pp. 510–513). Oxford: Oxford University Press.

- Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences: a practical guide*. Oxford: Blackwell.
- Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rogers, M., . . . Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: a product from the ESRC Methods Programme*. Retrieved from http://www.researchgate.net/profile/Mark_Rodgers4/publication/233866356_Guidance_on_the_conduct_of_narrative_synthesis_in_systematic_reviews_A_product_from_the_ESRC_Methods_Programme/links/02e7e5231e8f3a6183000000.pdf.
- Potgieter, J., & Botha, K. (2014). Functioning well. In M. Wissing, J. Potgieter, T. Guse, T. Kumalo, & L. Nel, *Towards flourishing: Contextualising positive psychology* (pp. 39-76). Pretoria: van Schaik.
- Pretorius, D., Van Rooyen, M., & Reinbrech-Schutte, A. (2010). *Patient-centred communication and counselling: Principles and practice*. Cape Town: Juta & Company Ltd.
- Quinley, K., Ratcliffe, J., & Schreiber, C. (2014). Psychological coping in the immediate post-abortion period. *Journal of Women's Health, 23*(1), 44-50.
- Robinson, G. E., Stotland, N. L., Russo, N. F., Lang, J. A., & Occhiogrosso, M. (2009). Is there an "abortion trauma syndrome"? Critiquing the evidence. *Harvard Review of Psychiatry, 17*, 268–290.
- Robson, S. (2006). *Developing thinking and understanding in young children: An introduction for students*. Abingdon: Routledge.

- Roesch, S. C., Aldridge, A. A., Huff, T. L., Langner, K., Villodas, F., & Brandshaw, K. (2009). On the dimensionality of the proactive coping inventory: 7, 5, 3 factors? *Anxiety, Stress & Coping*, *22*, 327-339.
- Rogers, C. R. (1974). A theory of therapy and personality change: As developed in the client-centred framework. In R. Morris (Ed.), *Perspectives in abnormal behavior* (pp. 341-350). New York: Pergamon Press Inc.
- Rubin, L., & Russo, N. (2004). Abortion and mental health: What therapists need to know. *Women & Therapy*, *27*(3/4), 9-90.
- Sa´nchez-Siancas, L. E., Rodri´guez-Medina, A., Piscoya, A., & Bernabe-Ortiz, A. (2018). Association between perceived social support and induced abortion: A study in maternal health centers in Lima, Peru. *PLOS ONE*, *13*(4), 1–11.
- Schünemann, H. J., & Moja, L. (2015). Reviews: Rapid! Rapid! Rapid! ...and systematic. *Systematic Reviews*, *4*(4).
- Schwartz, R., & Taubert, S. (2002). Tenacious goal pursuits and striving toward personal growth: Proactive coping. In E. Frydenberg, *Beyond coping: Meeting goals, visions and challenges* (pp. 19–35). London: Oxford University Press.
- Schwarzer, R. (2001). Stress, resources, and proactive coping. *Applied Psychology: An International Review*, *50*(3), 400-407.
- Schwarzer, R., & Knoll, N. (2003). Positive coping: Mastering demands and searching for meaning. In S. J. Lopez, & C. R. Snyder, *Handbook of positive psychological assessment*. Washington, DC: American Psychological Association.

- Sedgh, G., Singh, S., & Hussain, R. (2014). Intended and unintended pregnancies worldwide in 2012 and recent trends. *Studies in Family Planning, 45*(3), 310.
- Seligman, M., Rashid, T., & Parks, A. (2006). Positive psychotherapy. *American Psychologist, 61*, 774-788.
- Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among patients in the USA: An exploration by race and Hispanic ethnicity. *International Journal of Gynecology and Obstetrics, 118*(2), 152–159.
- Singh, S., Remez, L., Sedgh, G., Kwok, L., & Onda, T. (2018, March). *Abortion worldwide 2017: Uneven progress and unequal access*. Retrieved from <https://www.guttmacher.org/report/abortion-worldwide-2017>
- Skinner, E. A., & Zimmer-Gembeck, M. J. (2009). Challenges to the developmental study of coping. In E. A. Skinner, & M. J. Zimmer-Gembeck, *Coping and the development of regulation. New directions for child and adolescent development* (pp. 5-17). San Francisco: Jossey-Bass.
- Skosana, I. (2014, September 26). Abortion turns into a nightmare. *Mail and Guardian Africa's Best Read*. Retrieved from <http://mg.co.za/article/2014-09-26-abortion-turns-into-a-nightmare>
- Sniehotta, F. (2009). Towards a theory of intentional behaviour change: Plans, planning, and self-regulation. *British Journal of Health Psychology, 14*, 261–273.
- Snyder, C. R., & Dinoff, B. L. (1999). Coping. Where have you been? In C. R. Snyder, *Coping* (pp. 3-19) New York, NY: Oxford University Press.

- Sohl, S. J., & Moyer, A. (2009). Refining the conceptualization of an important future-orientated self-regulatory behavior: Proactive coping. *Personality and Individual Differences, 47*(2), 139–144.
- South Africa. (1996). *Choice on Termination of Pregnancy Act, 92 of 1996*. Pretoria: Government Printer.
- South Africa. (2008). *Choice on Termination of Pregnancy Amendment Act, 1 of 2008*. Pretoria: Government Printer.
- Steinberg, J. R., & Russo, N. F. (2009). Evaluating research on abortion and mental health. *Contraception, 80*, 500–503.
- Steinberg, J. R., Tschann, J. M., Furgerson, D., & Harper, C. C. (2016). Psychological factors and pre-abortion psychological health: The significance of stigma. *Social Science and Medicine, 150*, 67–75. doi:10.1016/j.socscimed.2015.12.007
- Straud, C., Mcnaughton-Cassill, M., & Fuhrman, R. (2015). The role of the five-factor model of personality with proactive coping and preventative coping among college students. *Personality and Individual Differences, 83*, 60–64.
- Subramaney, U., Wyatt, G. E., Williams, J. K., Zang, M., Liu, H., & Chin, D. (2015). Depressive and post-traumatic stress symptoms following termination of pregnancy in South African women: A longitudinal study measuring the effects of chronic burden, crisis support and resilience. *The South African Medical Journal, 105*(11), 934–938.
- Suffla, S. (1997). Experiences of induced abortion among a group of South African women. *South African Journal of Psychology, 27*, 214–222.

- Sullivan, M. E., Harrison, A., Harries, J., Sicwebu, N., Rosen, R. K., & Galarraga, O. (2017). Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study. *Health Care for Women International*, 1–14. doi:10.1080/07399332.2017.1400034
- Swann, W., & Jetten, J. (2017). Restoring agency to the human actor. *Perspectives on Psychological Science*, 12(3), 382-399.
- Taft, A. J., & Watson, L. F. (2007). Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. *Australian and New Zealand Journal of Public Health*, 31(2), 135-142.
- Taft, A. J., & Watson, L. F. (2008). Depression and termination of pregnancy (induced abortion) in a national cohort of young Australian women: The confounding effect of women's experience of violence. *BMC Public Health*, 8(1), 75.
- Templeton, A., & Grimes, D. (2011). Clinical practice. A request for abortion. *The New England Journal of Medicine*, 2198-2204.
- The American College of Obstetricians and Gynaecologists. (2014, November). Increasing access to abortion. *The American college of obstetricians and gynaecologists: Women's health care physicians*. Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>
- Thobejane, R. K. (2001). An investigation into the emotional reactions of black adolescent girls a week following an induced elective termination of pregnancy. *Medical University of Southern Africa, Pretoria*.

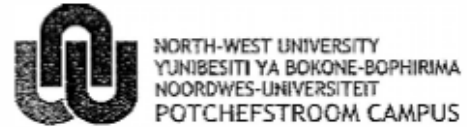
- Tingl f, S., H gberg, U., Lundell, I. W., & Svanberg, A. S. (2015). Exposure to violence among women with unwanted pregnancies and the association with post-traumatic stress disorder, symptoms of anxiety and depression. *Sexual and Reproductive Healthcare*, 6(2), 50-53.
- Torriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, South Africa. *African Journal of Nursing and Midwifery*, 119–131.
- Tracey, J. S. (2010). Qualitative quality: Eight "big tent" criteria for excellent qualitative research. *Qualitative Inquiry*, 16, 837-851.
- Trueman, K. A., & Magwetshu, M. (2013). Abortion in a progressive legal environment: The need for vigilance in protecting and promoting access to safe abortion services in South Africa. *American Journal of Public Health*, 397–399.
- Tyson, P. (2005). Affects, agency, and self-regulation: Complexity theory in the treatment of children with anxiety and disruptive behavior disorders. *Journal of the American Psychoanalytic Association*, 53(1), 159–187.
- UnitedHealthcare. (2017). *Abortions (therapeutic and elective)*. Oxford: Oxford Health Plans, LLC.
- Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010). Informing abortion counselling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Education and Counselling*, 81, 415–421.

- Van Ditzhuijzen, J., Ten Have, M., De Graaf, R., Lutig, P., Van Nijnatten, C. H., & Vollebergh, W. A. (2017). Incidence and recurrence of common mental disorders after abortion: Results from a prospective cohort study. *Journal of Psychiatric Research, 84*, 200–206.
- Van Ditzhuijzen, J., Ten Have, M., De Graaf, R., Van Nijnatten, C. H., & Vollebergh, W. A. (2015). The impact of psychiatric history on women's pre- and postabortion experiences. *Contraception, 92*, 246–253.
- Van Harreveld, F., Van der Pligt, J., & de Liver, Y. (2009). The agony of ambivalence and ways to resolve it: Introducing the MAID model. *Personality and Social Psychology Review, 13*(1), 45-61.
- Vancouver, J. B., & Day, D. V. (2005). Industrial and organisational research on self-regulation: from constructs to applications. *Applied Psychology, 54*(2), 155–185.
- Vincent, L. (2012). Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order - a view from South Africa. *Culture, Health and Sexuality, 14*(2), 125-138.
- Wager, E., & Wiffen, P. (2011). Ethical issues in preparing and publishing systematic reviews. *Journal of Evidence-Based Medicine, 4*, 130-134.
- Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2016). Six steps in quality intervention development. *Journal of Epidemiological Community Health, 70*(5), 520-525.
- Wissing, M. (2014). A path towards flourishing. In M. Wissing, J. Potgieter, T. Guse, T. Kumalo, & L. Nel, *Towards flourishing: Contextualising positive psychology* (pp. 3-15). Pretoria: Van Schaik Publishers.

- World Health Organization. (2015). *Health worker roles in providing safe abortion care and post-abortion contraception*. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=2D3AA66C5F642CB8A527D442B1152658?sequence=1
- World Health Organization. (2008, November 5). *Managing incomplete abortion. Education material for teachers of midwifery; midwifery educational modules*. Retrieved from http://whqlibdoc.who.int/publications/2008/9789241546669_3_eng.pdf
- World Health Organization. (2013). Post-abortion Care. In W. H. Organization, *A handbook for building skills: Counselling for maternal and newborn health care* (pp. 103–112). Geneva: World Health Organization Press.
- Yardley, L., Ainsworth, B., Arden-Close, E., & Muller, I. (2015). The person-based approach to enhancing the acceptability and feasibility of interventions. *Pilot and Feasibility Studies, 1*(37), 1-7. doi:10.1186/s40814-015-0033-z
- Zaki, J., & Williams, W. C. (2013). Interpersonal emotion regulation. *Emotion, 13*(5), 803–810. doi:10.1037/a0033839
- Zimmerman, B. J. (2000). Attaining self-regulation: A social cognitive perspective. In M. Boekaerts, P. R. Pintrich, & M. Zeidner, *Handbook of self-regulation* (pp. 13–35). San Diego: Academic Press.

Addendum 1

Informed Consent – Stage 1



PARTICIPANT (Stage 1 interview) INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

The nature and dynamics of coping with induced abortion in young adult women

REFERENCE NUMBERS:

PRINCIPAL INVESTIGATOR: Prof. Karel Botha

CO-INVESTIGATOR: Dr. Lynn Preston

PhD STUDENT: Mrs. Roché Lyon

ADDRESS: Dept of Psychology, Potchefstroom campus, NWU

CONTACT NUMBER: 018 – 299 1726 or 073 0660 173

You are being invited to take part in a research project that forms part of a PhD research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU -00059-16-S1) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- We would like to explore how young adult females experience and cope with abortion, and we would like to develop a brief coping intervention model for use by psychologists, counsellors and health care workers.

Why have you been invited to participate?

- You have been invited to participate because you have had a legally induced abortion within the past month at the Reproductive Health Clinic of the Potchefstroom Hospital, a public abortion service provider in South Africa.
- You have also complied with the following inclusion criteria:
 - aged 18 to 35 years
 - South African resident from any ethnic/racial group
 - able to understand and express yourself in Setswana, English and/or Afrikaans
- You will be excluded if:
 - the abortion was done in an illegal context
 - you had an abortion at a private clinic and not at the Reproductive Health Clinic of the Potchefstroom Hospital, a public abortion service provider in South Africa.
 - you know or are related to any of the researchers.

What will your responsibilities be?

- If you give permission to partake in the study, you will have to take part in an individual interview with the researcher in which you will tell us about your abortion experience and how you coped with the abortion. The interview will take about 30 to 45 minutes. The interview will also be audiotape-recorded to help us with the data analysis.

Will you benefit from taking part in this research?

- There are no direct benefits of taking part in this research study. However you could indirectly benefit as you will get the opportunity to share your abortion story with the researcher.
- Another indirect benefit will be to contribute to knowledge which will guide future research that could help someone else who will also experience an abortion.

Are there risks involved in your taking part in this research?

- You might experience some emotional discomfort when telling the researcher about your experience during the interview.
- The researchers are confident that the benefits of taking part outweigh the risk.

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

- A counsellor will be available immediately after you have completed the interview. Remember that you may withdraw during any stage of the research process.

Who will have access to the data?

- Only the three researchers, prof. Botha, dr. Preston and mrs. Lyon, will have access to and work with the data. Your identity will however at no stage be indicated or disclosed anywhere.

What will happen with the data/samples?

- Data will be kept safe in a password protected computer and in a locked safe in the project leader's office at the NWU. Once the study has been completed, data will be transferred to the safe of the research entity's office and be deleted from the project leader's computer.
- The data will be used to submit the study for publication – the manuscript will however not identify any participant and present data only in aggregate table format.

Will you be paid to take part in this study and are there any costs involved?

- No, you will not be paid to take part in the study. However your travelling expenses (to and from the hospital) will be covered. We will also offer some refreshments and a journal as a token of appreciation.

Is there anything else that you should know or do?

- Please contact prof. Karel Botha at 018 – 299 1726 or 073 0660 176 if you have any further questions.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2089; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- You may request to receive a full electronic copy of the published manuscript. In addition, you may request a brief feedback session at the Counselling Centre. This can be arranged and communicated to you once the research has been completed.

Declaration by participant

By signing below, I agree to take part in a research study titled: *The nature and dynamics of coping with induced abortion in young adult women*

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (*name*) declares that:

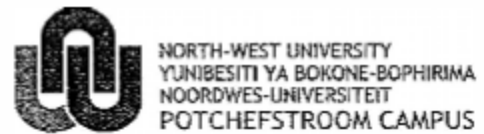
- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of researcher

.....
Signature of witness

Informed Consent – Stage 2



PARTICIPANT (Stage 2 questionnaire) INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

The nature and dynamics of coping with induced abortion in young adult women

REFERENCE NUMBERS:

PRINCIPAL INVESTIGATOR: Prof. Karel Botha

CO-INVESTIGATOR: Dr. Lynn Preston

PhD STUDENT: Mrs. Roché Lyon

ADDRESS: Dept of Psychology, Potchefstroom campus, NWU

CONTACT NUMBER: 018 – 299 1726 or 073 0660 173

You are being invited to take part in a research project that forms part of a PhD research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU -00059-16-S1) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- We would like to explore how young adult females experience and cope with abortion, and we would like to develop a brief coping intervention model for use by psychologists, counsellors and health care workers.

Why have you been invited to participate?

- You have been invited to participate because you have had a legally induced abortion within the past month at the Reproductive Health Clinic of the Potchefstroom Hospital, a public abortion service provider in South Africa.
- You have also complied with the following inclusion criteria:
 - aged 18 to 35 years
 - South African resident from any ethnic/racial group
 - able to understand and express yourself in Setswana, English and/or Afrikaans
- You will be excluded if:
 - the abortion was done in an illegal context
 - you had an abortion at a private clinic and not at the Reproductive Health Clinic of the Potchefstroom Hospital, a public abortion service provider in South Africa.
 - you know or are related to any of the researchers.

What will your responsibilities be?

- If you give permission to partake in the study, you will have to complete a confidential questionnaire indicating how you see the relationship between your abortion experience and how you coped with the abortion. The questionnaire will not take longer than 30 minutes to complete.

Will you benefit from taking part in this research?

- You could indirectly benefit as you will get the opportunity to contribute to knowledge which will guide future research on how women experience and cope with abortion.

Are there risks involved in your taking part in this research?

- You might experience some fatigue as you will have to concentrate when completing the questionnaire.
- The researchers are confident that the benefits of taking part outweigh the risk.

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

- A counsellor will be available immediately after you have completed the questionnaire. Remember that you may withdraw during any stage of the research process.

Who will have access to the data?

- Only the two researchers, prof. Botha, dr. Preston and mrs. Lyon, will have access to and work with the data. Your identity will however at no stage be indicated or disclosed anywhere.

What will happen with the data/samples?

- Data will be kept safe in a password protected computer and in a locked safe in the project leader's office at the NWU. Once the study has been completed, data will be transferred to the safe of the research entity's office and be deleted from the project leader's computer.
- The data will be used to submit the study for publication – the manuscript will however not identify any participant and present data only in aggregate table format.

Will you be paid to take part in this study and are there any costs involved?

- No, you will not be paid to take part in the study.

Is there anything else that you should know or do?

- Please contact prof. Karel Botha at 018 – 299 1726 or 073 0660 176 if you have any further questions.

- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2089; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- You may request to receive a full electronic copy of the published manuscript. In addition, you may request a brief feedback session at the Counselling Centre. This can be arranged and communicated to you once the research has been completed.

Declaration by participant

By signing below, I agree to take part in a research study titled: *The nature and dynamics of coping with induced abortion in young adult women*

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to

- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (*name*) Sister Seobi declares that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of researcher

.....
Signature of witness

Addendum 2

Questionnaire

STRICTLY CONFIDENTIAL

IQA – QUESTIONNAIRE

(Phase 2: **NWU -00059-16-S1**)

Dear participant:

Thank you for being willing to take part in this research study about women's experiences and coping with abortion. You have been invited to participate in this study because you have experienced a legal induced abortion. We are interested in the typical thoughts and feelings that you experience through the whole abortion process. From in-depth individual interviews conducted with participants, 13 themes were identified. Each of the 13 themes are described on page 2. Please familiarize yourself with each theme, before you answer the questionnaire itself, starting on page 3.

The questionnaire aims to explore how you perceive the cause-effect relationship between the different themes as it relates to your experience. Please have a look at how you should complete the questionnaire below:

You have to indicate in the center column, how you think different aspects of the abortion influence/cause each other. You have 3 options to choose from in each case:

For example, if in your experience, HAPPINESS AND SLEEPING WELL DON'T INFLUENCE or CAUSE EACH OTHER, you indicate:

Happiness	○	Sleeping well	
-----------	---	---------------	--

If however, HAPPINESS CAUSES YOU TO SLEEP WELL, you indicate:

Happiness	→	Sleeping well	
-----------	---	---------------	--

Or if it is rather SLEEPING WELL THAT CAUSES YOU TO FEEL HAPPY, you indicate:

Happiness	←	Sleeping well	
-----------	---	---------------	--

In other words, indicate each time what reflects YOUR experience regarding the abortion the best. There is **NO** right or wrong answers. Please only make one symbol in each block. **DO** not leave any blocks open.

The questionnaire will take you about 30 minutes to complete. Please ask the researcher to help if you are not sure what to do. You may start when you are ready.

Thank you

Roché Lyon and Prof. Karel Botha

THEMES

No.	Theme	Description
1	Feeling anxious and afraid	The experience of anxiety and fear. Being scared through (before/during/after) the abortion process.
2	Feeling traumatized	Being shocked and still experiencing anxiety and fear about the abortion today. Repeating thoughts and dreams about the abortion.
3	Feeling sad or depressed	Feeling sad or down. Crying about the abortion and feeling like you have lost something.
4	Feeling guilt or regret	Any feeling of guilt or regret. Thinking you should not have decided to have the abortion.
5	The abortion	This theme refers to all the aspects of the abortion. The whole process of terminating the pregnancy. This includes: the decision made to have an abortion, the abortion procedure and the experience of the abortion specifically the physical pain as well as the emotions experienced.
6	Tension with my family and community	Any stress experienced in your relationships with your family, the father of the baby, friends and the community in general. It also refers to existing tension/stress in your relationships before the unwanted pregnancy.
7	Unsupportive or absent father of the baby	The father of the baby is absent and provides no support to you. This includes both financial and emotional support.
8	Unhelpful nursing staff	The experience of unhelpful nursing staff during the whole abortion process. This includes nursing staff not being supportive, being judgmental and being unfriendly or rude.
9	Trying to forget thoughts and emotions	The effort of trying to forget everything about the abortion. Trying not to think about the emotions you experienced before, during or after the abortion.
10	Praying to God	Praying or talking to God about the abortion experience and your decision to have an abortion. Asking God for help or forgiveness.
11	Avoiding talking to others	Not talking to others and preferring to be alone. Keeping the abortion a secret and not telling anyone. This includes not talking to family, the father of the baby, friends and professionals like counsellors.
12	Thinking deeply, trying to understand and what to do next	The decision to have an abortion was well thought through and your own decision. Thinking deeply about the abortion and trying to understand what happened. This also includes thinking about what others might think about your decision to have an abortion. Thinking about your future and what this abortion meant to you. For example: lessons learned, being able to start a new life and not making the same decisions again.
13	Feeling relieved	You are glad and relieved that everything is over and that you are able to move on with your life.

PLEASE COMPLETE

MARK THE CENTER COLUMN WITH EITHER ○ OR → OR ←

In my experience of the abortion:

1	Feeling traumatized (2)		Praying to God (10)	
2	Unsupportive or absent father of the baby (7)		Avoiding talking to others (11)	
3	Thinking deeply, trying to understand and what to do next (12)		Feeling guilt or regret (4)	
4	The abortion (5)		Feeling traumatized (2)	
5	Feeling relieved (13)		Unhelpful nursing staff (8)	
6	Tension with my family and community (6)		Avoiding talking to others (11)	
7	Feeling sad or depressed (3)		Feeling anxious and afraid (1)	
8	Feeling guilt or regret (4)		Tension with my family and community (6)	
9	Avoiding talking to others (11)		The abortion (5)	
10	Feeling anxious and afraid (1)		Thinking deeply, trying to understand and what to do next (12)	
11	Tension with my family and community (6)		Unsupportive or absent father of the baby (7)	
12	Feeling guilt or regret (4)		Feeling sad or depressed (3)	
13	Praying to God (10)		Unhelpful nursing staff (8)	
14	Feeling guilt or regret (4)		Feeling traumatized (2)	
15	Unhelpful nursing staff (8)		Avoiding talking to others (11)	
16	Avoiding talking to others (11)		Praying to God (10)	
17	Feeling anxious and afraid (1)		Trying to forget thoughts and emotions (9)	
18	Feeling sad or depressed (3)		Feeling relieved (13)	
19	Feeling traumatized (2)		Unsupportive or absent father of the baby (7)	
20	Unsupportive or absent father of the baby (7)		Feeling guilt or regret (4)	

21	Thinking deeply, trying to understand and what to do next (12)		Tension with my family and community (6)
22	Feeling sad or depressed (3)		The abortion (5)
23	Feeling relieved (13)		Tension with my family and community (6)
24	Thinking deeply, trying to understand and what to do next (12)		Unhelpful nursing staff (8)
25	Tension with my family and community (6)		Feeling sad or depressed (3)
26	The abortion (5)		Praying to God (10)
27	Praying to God (10)		Thinking deeply, trying to understand and what to do next (12)
28	Unhelpful nursing staff (8)		Feeling traumatized (2)
29	Tension with my family and community (6)		Praying to God (10)
30	Unhelpful nursing staff (8)		Trying to forget thoughts and emotions (9)
31	Feeling anxious and afraid (1)		Unsupportive or absent father of the baby (7)
32	Trying to forget thoughts and emotions (9)		Feeling relieved (13)
33	Feeling sad or depressed (3)		Praying to God (10)
34	Thinking deeply, trying to understand and what to do next (12)		Avoiding talking to others (11)
35	The abortion (5)		Trying to forget thoughts and emotions (9)
36	Unhelpful nursing staff (8)		Feeling anxious and afraid (1)
37	Tension with my family and community (6)		Trying to forget thoughts and emotions (9)
38	Avoiding talking to others (11)		Feeling relieved (13)
39	Feeling traumatized (2)		Feeling sad or depressed (3)
40	Praying to God (10)		Unsupportive or absent father of the baby (7)
41	Unhelpful nursing staff (8)		The abortion (5)
42	Feeling traumatized (2)		Thinking deeply, trying to understand and what to do next (12)
43	Avoiding talking to others (11)		Trying to forget thoughts and emotions (9)
44	Feeling relieved (13)		Praying to God (10)

45	Tension with my family and community (6)		Feeling anxious and afraid (1)	
46	The abortion (5)		Feeling guilt or regret (4)	
47	Unhelpful nursing staff (8)		Tension with my family and community (6)	
48	Feeling anxious and afraid (1)		Feeling traumatized (2)	
49	Feeling relieved (13)		Feeling traumatized (2)	
50	Feeling traumatized (2)		Avoiding talking to others (11)	
51	Feeling sad or depressed (3)		Unhelpful nursing staff (8)	
52	Tension with my family and community (6)		The abortion (5)	
53	Feeling guilt or regret (4)		Feeling anxious and afraid (1)	
54	The abortion (5)		Thinking deeply, trying to understand and what to do next (12)	
55	Trying to forget thoughts and emotions (9)		Feeling sad or depressed (3)	
56	The abortion (5)		Unsupportive or absent father of the baby (7)	
57	Feeling traumatized (2)		Tension with my family and community (6)	
58	Unhelpful nursing staff (8)		Feeling guilt or regret (4)	
60	Avoiding talking to others (11)		Feeling sad or depressed (3)	
61	Unsupportive or absent father of the baby (7)		Trying to forget thoughts and emotions (9)	
62	The abortion (5)		Feeling relieved (13)	
63	Praying to God (10)		Feeling guilt or regret (4)	
64	Feeling anxious and afraid (1)		Avoiding talking to others (11)	
65	Feeling traumatized (2)		Trying to forget thoughts and emotions (9)	
66	Thinking deeply, trying to understand and what to do next (12)		Feeling sad or depressed (3)	

67	Feeling anxious and afraid (1)		Feeling relieved (13)	
68	Avoiding talking to others (11)		Feeling guilt or regret (4)	
69	Praying to God (10)		Feeling anxious and afraid (1)	
70	Unsupportive or absent father of the baby (7)		Unhelpful nursing staff (8)	
71	Feeling relieved (13)		Feeling guilt or regret (4)	
72	Trying to forget thoughts and emotions (9)		Praying to God (10)	
73	Unsupportive or absent father of the baby (7)		Feeling relieved (13)	
74	Unsupportive or absent father of the baby (7)		Feeling sad or depressed (3)	
75	Trying to forget thoughts and emotions (9)		Thinking deeply, trying to understand and what to do next (12)	
76	Feeling anxious and afraid (1)		The abortion (5)	
77	Feeling guilt or regret (4)		Trying to forget thoughts and emotions (9)	
78	Feeling relieved (13)		Thinking deeply, trying to understand and what to do next (12)	

Addendum 3

**Guidelines to facilitate effective coping in young adult women undergoing
legal induced abortion**

Compiled by Roche Lyon

Index

Introduction: context, prerequisites and ethics

Table 8: Terminology

Theoretical approach

The person-centred approach

The strengths approach

Change mechanisms

Guideline set 1 - *Counsellor to reflect on own possible biases*

Guideline set 2 – *Understanding and reappraising context*

Guideline set 3 – *Promoting clients' coping skills*

Table 9: Summary

Introduction: context, prerequisites and ethics

These guidelines have been designed specifically for counsellors working at public hospitals in South Africa to enable them to facilitate effective coping skills in women who have decided to undergo a legal induced abortion. The guidelines have not been evaluated, but are based on two studies the researcher conducted as part of her PhD in Psychology. The guidelines do not stipulate components like budget and time planning; policy-related issues; matters related to the law and ethics, like consent; or the details of the abortion procedure followed. It is extremely important to remember that the implementation of these guidelines should always be subject to the legal and ethics structures of the service provider.

In South Africa, the Choice on Termination of Pregnancy Act (92 of 1996) (South Africa, 1996), allows for non-mandatory non-directive counselling for women seeking abortion. Abortion is a complex experience that interlinks with the difficult decision not to continue with an unwanted pregnancy. The experience is further complicated by social stigma, a lack of financial resources, partner violence, and the absence of proper abortion counselling services. These problems are especially prominent in South Africa. This complex integration of individual and socio-political factors challenge women's self-regulatory coping efforts to such an extent that psychological growth seems to be limited. Such guidelines for counselling should foster awareness and sensitivity to the context of the situation and should facilitate processes that lessen the paradoxes women experience regarding constructive prevention and promotion of unwanted pregnancies.

Finally, it **is strongly recommended** that a psychologist or registered counsellor provides training on how to effectively implement the guidelines.

Table 8: Terminology

Term	Definition
Abortion	A medically induced miscarriage using pharmacological means and / or surgical procedures (Torriente, Joubert, & Steinberg, Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, Sout Africa, 2016).
Agency	An individual's ability to make things happen by means of his/her own ("self") actions (Bandura, Toward a Psychology of Human Agency: Pathways and Reflections, 2018). Includes volitional, goal-directed behaviour (Little, Hawley, Henrich, & Marsland, 2002).
Ambivalence	The experience of contradictory thoughts or feelings about something or someone (van Harreveld, van der Pligt, & de Liver, 2009).
Anxiety	An emotion characterized by worry or a dread of something. A response to a vague or unknown threat, internal or external (Grivas, 2006).
Autonomy	Having a sense of being able to behave independently. Feelings of self-control, self-reliance, self-confidence and competence may accompany this (Grivas, 2006).
Avoidance coping	Reduction of stress by taking actions to avoid direct contact with the stressor (Carver & Connor-Smith, 2010).
Context	The circumstances around an event or situation. The interrelated conditions in which something exists or occurs (Merriam Webster, 2018).
Control	To exercise restraining or directing influence, to regulate (Merriam Webster, 2018).
Coping	The thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful (Folkman & Moskowitz, 2004).

Term	Definition
Counselling	Consultation between a counsellor and client, usually a session characterized by support, active listening and facilitation of action or behaviour.
Counsellor	A person who is professionally trained to assist people in dealing with problems associated with personal adjustment, relationships, stress, chronic pain etc. (Grivas, 2006). In South Africa, a registered counsellor's primary function is to prevent, promote, intervene and refer (HPCSA, 2013).
Depression	A mood state characterized primarily by sadness, ranging from mild sadness through to acute despair (Grivas, 2006).
Emotion	A personal experience that involves a mixture of physiological responses, subjective feelings and expressive behaviour (Grivas, 2006).
First trimester	First twelve weeks of pregnancy.
Guilt	A negative feeling that something one has done or wants to do is wrong (Grivas, 2006).
Lack of Support	Minimized support or total absence of support.
Legal induced abortion	Also known as termination of pregnancy. It refers to a medically induced miscarriage using pharmacological means and / or surgical procedures within the first twelve weeks of pregnancy.
Non-directive counselling	Counselling without direction, influence or stigma.
Pain	An unpleasant sensation or response to a stimulus that can occur in varying degrees of intensity. Pain can either be physical or emotional.
Partner violence	Violence perpetrated by a partner, also known as domestic violence and characterized by a multi-dimensional set of coercive behaviors, mostly physical violence (Taft & Watson, 2007).
Person-centred	Counselling centered around the needs of the client (Mavuso, Du Toit,

Term	Definition
counselling	Macleod, & Stevens, 2018).
Personality characteristics	A group of relatively unchanging personal characteristics that is unique to an individual and determines their thoughts, feelings and behaviour in a wide range of situations (Grivas, 2006).
Pray	Conversations with a divinity.
Premorbid factor	A state or condition that had occurred or existed before a certain time; in this case before the abortion.
Relief	A feeling of lightening of something painful or distressing (Merriam Webster, 2018).
Self-reflection	To inspect and evaluate your cognitions, emotions and behaviours (Grant, Franklin, & Langford, 2002).
Self-regulation	Self-regulation as a form of coping (Aldwin, Skinner, Zimmerman, & Taylor, 2011) is the process of modulating and readjusting one's emotions, moods, thoughts, physiological state and actions to challenging or stressful contexts (such as abortion) to achieve an anticipated position or to move away from undesired conditions (McClelland & Cameron, 2012; Carver & Scheier, 1998; 2016; 2017). The processes involved in attaining and maintaining goals (Vancouver & Day, 2005).
Social disadvantage	Socially devalued, materially disadvantaged, having to deal with negative stereotypes, prejudice and overt discrimination (Major & Schmader, Legitimacy and the Construal of Social Disadvantage, 2001).
Stigma	A mark, brand or label that distinguishes one person from another in a negative way, usually marked by a sign of shame, disgrace or disapproval (Grivas, 2006).
Stress	Stress is defined as something that unsettles the physical- or intellectual wellbeing of an individual (Kafeel, et al., 2018)
Trauma	Physical or psychological injury or harm, or severe emotional distress

Term	Definition
Unplanned pregnancy	resulting from a threatening experience.
Unwanted pregnancy	A pregnancy that is not wanted or rejected.

Theoretical approach

You will have to position yourself as a counsellor in relation to two theoretical approaches. These two approaches emerge from research and are crucial in the success of abortion counselling.

The person-centred approach.

After gathering all the contextual information, you would be able to determine the client's individual needs. According to Yardley et al. (2015), a person-centred approach entails a sensitive mindfulness of the viewpoints and lives of clients and offers behaviour change interventions that provides insight into how different people may view different situations. The reason for recommending a person-centred approach is that women experience abortion as a challenging process with associated stigma, social isolation, rejection, guilt and ambivalence. Ely (2007) indicates that women need a friendly atmosphere in which they feel accepted and not judged. Therefore, a counsellor who is knowledgeable, able to normalize their experiences and counteract negative experiences, and able to provide information about the procedure while delivering support and assistance is invaluable. You can ensure that the counselling is person-centred and focused on the needs of the client by doing the following:

- Remember that the client's wishes are central.
- Listen carefully without judgement.
- Aim to meet the person and not the patient.
- Display accurate empathy by proverbially placing yourself in the "clients's shoes" and accurately reflecting the emotions she displays during your interactions at the appropriate intensities and times.
- Show unconditional positive regard and support (unconditional acceptance and support of the client regardless of what she says and does).

- Show congruency (be genuine and true to your own needs and feelings)
- Respond to the concerns raised by the client, rather than introducing your own views.
- Indicate that you understand the context within which the client requested the abortion.
- Be sensitive to the client's context and the differences in how different people appraise contexts differently.
- Allow for the expression of negative emotions, frustrations and difficulty in coping.
- Encourage the client to express herself by maintaining good eye contact, head nodding, verbal affirmation (mmm; yes; I understand), and questions such as “can you tell me more about that?”.

Remember the importance of professional confidentiality. Confidentiality will help create a safe atmosphere for the client, which will help her to feel safe to share personal information.

The strengths approach.

Counselling should in addition follow a strengths perspective, which emphasizes strengths rather than weaknesses or emotional pain (Biswas-Diener, Kashdan, & Minhas, 2011); Seligman, Rashid & Parks, 2006). The strengths approach aims to enhance quality of life by focusing on already existing resources and promoting optimal functioning (Wissing, 2014) and psychological well-being (Govindji & Linley, 2007). In abortion counselling it implies helping women to improve their resource and social support base in order to ensure psychological growth despite what they went through.

Ensure that the counselling follows a strengths approach by doing the following:

- Focus on resources and strengths the client already has at her disposal.
- Help the client to discover and enhance her existing resources and strengths.
- Aim to promote optimal functioning and not just survival.
- Provide the client with the information, skills, support and confidence to improve her decision making and sense of control.
- Encourage the client to believe in her own ability to make things happen.
- Don't just focus on the repair of dysfunctional coping.
- Recognize the client's ability to be resilient despite contextual challenges.
- Understand the importance of negative emotions and frustration within the context of coping as a self-regulatory perspective (negative emotions help the client and others understand what she is going through and what to change in order to improve her situation).
- Model flexible coping approaches (there are more than one way to perceive and manage current or anticipated future stressors).

Change mechanisms

Guideline 1 – *The counsellor’s ability to reflect on his or her own biases.*

Build an alliance with the client, as this will serve as a foundation that could encourage the woman to engage in the counselling session. Show empathy, even if you have to suspend your own beliefs, values and attitudes. Active listening is essential in building an alliance and supporting the client’s wishes.

Mirror non-judgement by:

- setting aside your own values and beliefs about abortion;
- setting aside preconceived ideas about women’s vulnerability;
- guarding against assuming that the client will find it difficult to cope;
- guarding against the idea that the client suffers a pathology;
- focusing on the client’s strengths rather than treating her impairments;
- showing empathy by trying to understand the client’s situation from her perspective and trying to understand her feelings;
- asking the client what she would like to discuss;
- actively listening to what the client has to say;
- asking only clarifying questions;
- acknowledging that abortion is a stressful event that most women are able to cope with effectively;
- normalizing the client’s feelings of ambivalence, lack of control, depression, anxiety, and guilt by assuring her that many other women have also felt this way and that it is normal when processing or dealing with an abortion;
- listening carefully to the client’s feelings, providing affirmation that you have heard and understanding her feelings by nodding your head, making good eye

contact and acknowledging her responses with sounds and gestures, such as “hmm”; “I understand” and

- allowing the client to express their emotions without judgement and stigma.

Provide information on the following:

- The client’s rights in terms of the Choice on Termination of Pregnancy Act (92 of 1996) (South Africa, 1996),
- The termination method, duration and potential side effects and complications of each procedure
- Any side effects of which the client should be aware

Adhere to the following dos and don’ts:

- Do not provide graphic information about the abortion process or the foetus.
- Do not provide developmental information about the foetus.
- Do not refer to the foetus as a “baby”.
- Do not direct the counselling by focusing on either the severe side-effects of abortion or on unrealistic benefits of abortion. Rather maintain a neutral front and only provide the client with the necessary evidence-based information.
- Mention to the client that she may find it helpful to share her experience with a friend or a counsellor.
- If the client requires referral, you may mention the possibility, but first get permission from the client to refer her before following through. The only circumstances in which referral is mandatory is when a client is clearly threatening harm to herself or others. In such a case, ask the client to wait and seek urgent assistance from the social worker or facility supervisor.
- Allow sufficient time for the client to ask questions and express any fears.

Guideline 2 – *Understanding and reappraising context.*

Listen to each individual's story and try to gain insight into the client's context. This includes the context of the unwanted pregnancy, the decision to abort, the abortion itself and the support system of the client. Listen carefully for any information regarding the woman's background, social disadvantages, experience of partner violence and perceived social stigma. Obtaining this information will enable you to gain insight that would help you tailor the counselling to the client's background and individual needs. Aim to guide the client towards identifying alternative appraisals of her context.

Take note of:

- The client's age
- The relationship status of the client
- Previous pregnancies and complications
- Duration of current pregnancy
- Current use of contraception
- Socio-economic factors
- Spiritual beliefs
- Family relations

If the client reveals that she is a victim of rape, sexual violence or domestic violence, address it strictly according to the hospital procedures.

Guideline 3 – *Promoting clients' coping skills in an effective way.*

- Understand the role negative emotions play in adverse situations and guide clients towards an appraisal that nothing is “wrong”.
- Allow the client to express their negative emotions, frustrations and difficulties in coping without judging or indicating that these feelings imply an obstacle for growth.
- If the client’s ideas about abortion are dysfunctional, re-evaluate the basis for those ideas and try to positively reframe them.
- Feelings like ambivalence, regret, sadness and guilt are normal after making such a difficult decision, and as the counsellor you have to recognize this and help the client to put their feelings into context.
- Aim to cultivate a feeling of control within the client.
- Ask the client if she would like to talk about contraception and if she does, provide her with the necessary information.
- Give the client acknowledgement of the validity of her current coping efforts, however, help her to understand that not all coping efforts are equally helpful.
- Acknowledge avoidance coping (if present) and ensure a supportive environment so that the client’s self-reflective coping strategies could be developed into constructive problem solving strategies in the long run.
- Provide the client with guidelines for future planning by establishing new life goals.
- Focus on approach goals rather than avoidance goals (in other words “what I want to achieve” rather than “what I don’t want in my life”).
- Teach and facilitate pro-active and problem-focused coping skills to ensure resilience in the long run by setting realistic, meaningful and attainable new goals.

- Aim to guide the client on how to flexibly apply different coping skills in different contexts. This will create a sense of autonomy and agency.
- Guide the client to identify and activate social support as a general resource, because it may serve either as a buffer in the coping process or may directly improve well-being.

Summary:

Table 9: A summary of the three change mechanisms in relation to the theoretical approach

Change mechanisms	How it is applied in counselling	
	Person-centred	Focused on strengths
1. Counsellor's ability to reflect on own biases	<i>Being self-congruent and inviting congruency from the client. Meeting the 'person' and not a 'patient'</i>	<i>Commit to the idea that clients do not necessarily need to be 'treated'. The aim of counselling should be facilitation of strengths and resources that already exist.</i>
2. Effectively understanding and reappraising context	<i>Unconditional positive regard. A trusting, supportive relationship with the client. Being sensitive to clients' context and differences in how context is appraised</i>	<i>Recognize client's ability to be resilient despite contextual challenges. Do not focus on what is wrong, but rather on what is "right", despite context.</i>
3. Effectively promoting clients' internal coping skills	<i>Allowing for expression of emotions through accurate reflection of feelings expressed by clients, especially negative emotions such as frustration, and difficulty in coping. Modelling flexible coping approaches.</i>	<i>Understand the importance of accurately acknowledging emotions, especially negative emotions like frustration in the context of coping as a self-regulatory process. Facilitate healthy coping.</i>

References

- Bandura, A. (2018). Toward a Psychology of Human Agency: Pathways and Reflections. *Perspectives on Psychological Science, 13*(2), 130-136.
- Biswas-Diener, R., Kashdan, T., & Minhas, G. (2011). A dynamic approach to psychological strength development and intervention. *The Journal of Positive Psychology, 6*(2), 106-118.
- Carver, C. S., & Connor-Smith, J. (2010). Personality and coping. *Annual Review of Psychology, 61*, 679-704.
- Carver, C. S., & Scheier, M. F. (1998). *On the self-regulation of behavior*. New York: Cambridge University Press.
- Carver, C. S., & Scheier, M. F. (2016). Self-regulation of action and affect. In K. D. Vohs, & R. F. Baumeister, *Handbook of self-regulation: Research, theory, and applications* (3rd ed., pp. 3-23). Guilford Press.
- Carver, C. S., & Scheier, M. F. (2017). Self-regulatory functions supporting motivated action. In A. J. Elliot, *Advances in motivational science* (3rd ed., Vol. 4, pp. 1-37). Cambridge, MA: Elsevier.
- Choice on Termination of Pregnancy Act 92 of 1996 see South Africa. (1996).
- Ely, E. (2007). The Abortion Counselling Experience: A Discussion of Patient Narratives and Recommendations for Best Practices. *Best Practices in Mental Health, 3*(2).
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology, 55*, 745-774.

- Grant, A., Franklin, J., & Langford, P. (2002). The Self-Reflection and Insight Scale: A new measure of private self-consciousness. *Social Behavior and Personality: An International Journal*, 30, 821-836.
- Grivas, J. (2006). *Oxford Psychology Study Dictionary* (2nd ed.). Oxford: Oxford University Press.
- Health Professions Council of South Africa. (2013, October 4). Professional Board for Psychology: Framework for education, training, registration and scope of registered counsellors. Retrieved from Health Professions Council of South Africa: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/psych/psycho_policy/form_258_registered_counsellor_%2004oct_2013.pdf
- Kafeel, T., Shoaib, R., Sohail, F., Yamin, F., Ahmed, I., & Paracha, H. (2018). Level of Stress among Doctor of Physical Therapy. *Indian Journal of Physiotherapy & Occupational Therapy*, 12(1), 112-117.
- Little, T. D., Hawley, P. H., Henrich, C. C., & Marsland, K. W. (2002). Three Views of the Agentic Self: A Developmental Synthesis. In E. L. Deci, & R. M. Ryan, *Handbook of Self-Determination Research* (p. 470). New York: University of Rochester Press.
- Major, B., & Schmader, T. (2001). Legitimacy and the Construal of Social Disadvantage. In J. T. Jost, & B. Major, *The Psychology of Legitimacy: Emerging Perspectives on Ideology, Justice, and Intergroup Relations* (p. 176). Cambridge: Cambridge University Press.
- Mavuso, J. M., Du Toit, R., Macleod, C. I., & Stevens, M. (2018, July 24). Retrieved from Sexual and Reproductive Justice Coalition: <https://srjc.org.za/2018/07/24/abortion-counselling-in-south-africa-a-step-by-step-guide-for-providers-2/>

- McClelland, M. M., & Cameron, C. E. (2012). Self-regulation in early childhood: Improving conceptual clarity and developing ecologically valid measures. *Child Development Perspectives, 6*, 136-142.
- Merriam Webster. (2018, October 8). *Merriam Webster Dictionary*. Retrieved from Merriam Webster: <https://www.merriam-webster.com/dictionary/context>
- Seligman, M., Rashid, T., & Parks, A. (2006). Positive psychotherapy. *American Psychologist, 61*, 774-788.
- South Africa. 1996. *Choice on Termination of Pregnancy Act 92 of 1996*. Pretoria: Government Printers.
- Taft, A. J., & Watson, L. F. (2007). Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. *Australian and New Zealand Journal of Public Health, 31*(2), 135-142.
- Torriente, M. C., Joubert, G., & Steinberg, W. J. (2016). Contraceptive use and reasons for termination of pregnancy among women attending a reproductive health clinic at a district hospital, Free State, Sout Africa. *Africa Journal of Nursing and Midwifery, 119-131*.
- van Harreveld, F., van der Pligt, J., & de Liver, Y. (2009). The agony of ambivalence and ways to resolve it: Introducing the MAID model. *Personality and Social Psychology Review, 13*(1), 45-61.
- Vancouver, J. B., & Day, D. V. (2005). Industrial and organisational research on self-regulation: from constructs to applications. *Applied Psychology, 54*(2), 155-185.

- Wissing, M. (2014). A Path Towards Flourishing. In M. Wissing, J. Potgieter, T. Guse, T. Kumalo, & L. Nel, *Towards Flourishing: Contextualising Positive Psychology* (pp. 3-15). Pretoria: Van Schaik Publishers.
- Yardley, L., Ainsworth, B., Arden-Close, E., & Muller, I. (2015). The person-based approach to enhancing the acceptability and feasibility of interventions. *Pilot and Feasibility Studies*, 1(37), 1-7. DOI: 10.1186/s40814-015-0033-z

Addendum 4

Declaration of Language Editing



Director: CME Terblanche - BA (Pol Sc), BA Hons (Eng), MA (Eng), TEFL

22 Strydom Street
Baillie Park, 2531

Tel 082 821 3083
cumlaudelanguage@gmail.com

DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrechia Terblanche, hereby declare that I edited the
research study titled:

**The nature and dynamics of coping with induced abortion in
young adult women**

for **Roché Lyon** for the purpose of submission as a postgraduate study for
examination. Changes were indicated in track changes and implementation
was left up to the author.

Regards,

CME Terblanche

Cum Laude Language Practitioners (CC)

SATI accr nr: 1001066

Registered with PEG