The Relationship of Perceived Maternal Conflict to Grief Intensity in a Genetically Indicated Abortion

by

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B.S.N., The University of British Columbia, 1986

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

The School of Nursing

We accept this thesis as conforming

to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

August, 1990

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Date August 29, 1990

DE-6 (2/88)

Abstract

The incidence of congenital anomalies or potential congenital anomalies of fetuses is two to three percent. Most women who have a positive diagnosis of a congenital anomaly choose to terminate the pregnancy. A review of the literature identifies conflict preabortion and grief postabortion as key variables for women terminating pregnancies for genetic indications. The purpose of this study was to study the degree of conflict in the decision-making process preabortion and the intensity of grief six weeks postabortion and to determine if a relationship exists between the conflict and grief variables.

This was a descriptive, correlational study which used summary statistics to analyze the data. Women responded to a questionnaire six weeks postabortion about conflict experienced pretermination and current grief experienced. The sample included nine women who aborted in the second trimester of pregnancy following either ultrasound, chorionic villi sampling, or alpha-fetoprotein analysis of the fetus.

The findings indicated that the women experienced conflict while deciding whether or not to abort the fetus and that at six weeks posttermination the intensity of grief experienced was still high. A scatter plot revealed a curvilinear relationship showing grief plateauing and then decreasing as the conflict scores rose. Recommendations were that objective counselling in the decision-making period prior to the termination be provided, and grief counselling should continue longer than six weeks posttermination for those who need counselling.

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Acknowledgements

I would like to thank my thesis committee members, Alison Rice and Helen Elfert, who shared with me their knowledge and expertise of the research topic and the research process. Appreciation is also extended to Dr. Walter Boldt for his willing and expert assistance with the statistical analysis of the data.

I would also like to thank the genetic associates of the Department of Medical Genetics, Shaughnessy Site, University Hospital, for recruiting the women for the study. In particular, Caroline Ganshorn was very helpful with this task.

And finally to my parents and Linda Yearwood-Dance, thank you for your support.

CHAPTER ONE

Introduction

Context of the Problem

"The desired and expected outcome of every wanted pregnancy is a normal, functioning infant with a good intellectual potential" (Jensen & Bobak, 1985). However, not all couples fulfill this hope. It is estimated that the background risk for any couple to have a child with major congenital anomalies noted at birth is 2-3% (Gatlin, 1985).

Advancements in technology and science allow some major congenital anomalies to be diagnosed prenatally. Chorionic villi sampling, diagnostic ultrasound, and amniocentesis are the major diagnostic techniques used in prenatal diagnosis. Presently, 300 congenital anomalies and genetic diseases can be diagnosed prenatally, and there is speculation that this figure will double in the next decade (Green & Malin, 1988). McKusick (1983) has recorded 3368 genetic disorders to date. This number is increasing as new genetic disorders continue to be recognized. However, not all of these conditions cause disease or are life threatening.

Holloway and Brock (1988) and Adams, Oakley, & Marks (1982) have predicted that there will be an increased demand for prenatal diagnosis by the year 2000. The increase in demand will be due to the increased number of older women (35-44) among all women of reproductive age (15-44) and increased fertility rates for the older group. With a higher incidence of chromosomal abnormalities in fetuses of older women (Selle,

Holmes, & Ingbar, 1979), there will be an increased demand for prenatal diagnosis.

An outcome of the advances in prenatal diagnosis and the increasing demand for prenatal diagnosis is an increase in the number of selective abortions for those women with a defective or potentially defective fetus. When a genetic abnormality is detected, most women decide to abort the fetus (Finley, Varner, Vinson, & Finley, 1977; Rayburn & LaFerla, 1982). For these women, the decision to abort is not made easily and is an emotional one. The decision may be difficult due to conflicting values such as personal values about abortion and disabled persons. As well, the political and social controversy that surrounds abortion adds to their burden. If the woman decides to abort, an emotional price is also paid in the grieving process.

Significance of the Problem

Little research has been done on abortions for genetic reasons. The small amount of research that has been done on this subject supports the notion that grief reactions do occur (Blumberg, Golbus & Hanson, 1975; Donnai, Charles, & Harris, 1981; Lloyd & Laurence, 1985). Conflict in the preabortion period is tentatively identified as a risk factor for grief in the postabortion period (McCall, 1987; Friedman, Greenspan, Mittleman, 1974; Lazarus, 1985; Payne, Kravitz, Notman, & Anderson, 1976). No research to date identifies conflict in the decision-making process prior to the abortion as an indicator of women at risk for intense grief postabortion. Considering the

increasing numbers of women who undergo prenatal diagnosis and the percentage of those who abort, it is important to identify antecedent risk factors for those who may suffer from intense grief. Health care resources can then be selectively apportioned to those in need.

Conceptual Framework

For women at risk of having a defective fetus, decisions about becoming pregnant, having prenatal diagnosis, and terminating the pregnancy are difficult. Unfortunately, the whole process may culminate in the painful process of grieving when the woman decides to terminate a wanted pregnancy where the fetus is defective or potentially defective. Janis and Mann's (1968) theory of conflict in the decision-making process and the University of British Columbia Model of Nursing (Campbell, 1987) frame the concepts of conflict and grief used in this study.

Conflict

The reality of a wanted/unwanted pregnancy can be examined using the idea of decision making under conflict. Early conflict studies by Lewin (1935) conceptualize the "life space" as the total milieu in which a person behaves; and within this milieu, positive and negative valences motivate a person toward or away from a specific goal. Behavior is considered to be a function of the person and his/her environment; therefore, a woman terminating or continuing her pregnancy acts according to the positive and negative valences within her life space.

Janis and Mann's (1968) theory of conflict in the decision-making process depicts five sequential stages which a

person goes through in making a successful decision. Each stage will be discussed in detail in relation to women deciding whether or not to terminate or continue their pregnancies.

In stage one, the decision maker is exposed to new information requiring some form of action. The acknowledgement that the fetus is defective or could be defective constitutes stage one and involves the beginning of a temporary personal crisis. The inconsistency between the new information and the woman's desire to have a healthy baby generates an acute conflict about the pregnancy. The first stage in the decision-making process ends when the woman has consciously realized and accepted the prenatal diagnosis.

In stage two, alternative forms of action are developed. The woman considers alternatives "to have a good chance of averting or minimizing the losses made salient by the challenge" (Janis & Mann, 1968, p. 330). The woman considers two possible outcomes--continuation of the preganancy or abortion. Abortion is not considered by some even when the pregnancy is unwanted because of strong personal or religious convictions, pressure of social norms, and/or the opposition of the partner (Bracken, 1974). Other factors supporting abortion as a viable alternative, such as the lack of social and economic support for disabled persons, may outweigh the personal and religious disapproval of abortion.

Stage three involves the evaluation of each alternative course of action. The woman selects the best alternative according to her personal criteria. To do this she scans and

weighs each alternative.

Janis and Mann (1968) present a balance sheet schema with each alternative positively and negatively evaluated. Four main categories are considered in the balance sheet with respect to anticipated favorable or unfavorable consequences of choosing a given alternative. Anticipated utilitarian gains or losses for self, anticipated utilitarian gains or losses for significant others, anticipated approval or disapproval from self, and anticipated approval or disapproval from significant others are considered.

The conflict a woman experiences when she must decide between abortion or continuation of a pregnancy where the fetus is defective or potentially defective represents the presence of two incompatible response tendencies. She experiences a high level of conflict if both tendencies are strong and her balance sheet includes a great number of powerful positive and negative forces (valences) (Bracken, 1974). Bracken states that "higher levels of conflict would result in higher levels of tension, sleeplessness, loss of appetite, and loss of sexual interest" (p. 33).

In stage three "bolstering" occurs. Bolstering is a process whereby the decision maker rehearses the role of having actually made a decision (Bracken, 1974; Janis and Mann, 1968). The woman may consider what her personal response to a disabled child would be and the responses of significant others. If this role does not feel comfortable, she may imagine what it would be like to abort a fetus which may have been the outcome of a planned pregnancy

and in which considerable attachment may have already occurred.

In stage four, the decision maker commits herself to the chosen outcome. The chosen course of action receives some psychological investment and the decision maker seeks support for it (Bracken, 1974). She may inform significant others, such as family members or friends. Bolstering of the chosen alternative continues perhaps by talking with those who have aborted for a similar reason or by reading articles on the topic. Usually, to avoid negative feedback, she speaks last to those who may be critical of her chosen action. The purpose of the bolstering is to increase the spread between the alternatives and to minimize postdecisional regret (the continuation of conflict after the action is taken) (Bracken, 1974). Bracken suggests that postdecisional regret is likely when bolstering of both alternatives, rather than just one, happens in stage three.

In stage five, there is adherence to the decision. The woman may reach this stage prior to the abortion or in the postpartum period. Challenging information, such as opposing attitudes or beliefs of society or significant others, is discounted or minimized. Janis and Mann (1968) suggest that "proselytizing to others about the wisdom of the choice" (p. 331) assists in conflict resolution.

Janis and Mann (1977) suggest that the quality of the decision may be measured by examining the process used to decide on a chosen course of action. A high quality decision would have considered all possible pregnancy outcomes and all the positive and negative consequences of each outcome. The woman would seek

out new information for further evaluation of alternative outcomes and experts would be consulted. Then all alternatives, even those which were considered unacceptable at first, are re-evaluated. She plans for anticipated problems and rehearses her response to them. For example, she rehearses how she would react to others who disagree with her decison to abort a defective or potentially defective fetus.

In the event that all possible pregnancy outcomes and all positive and negative consequences of each outcome are not considered in the process of decision-making, Janis and Mann (1968) suggest that postdecisional regret is possible. Postdecisional regret occurs when the decision maker is not able to discount the challenges of attitudes and behaviors of significant others. Since the abortion is irrevocable, the only route for the woman to overcome the regret is to crystallize or bolster her proabortion attitudes or attitudes related to disabled persons. Postdecisional regret is experienced as unpleasant tension, which is the same unpleasant tension experienced in the predecisional stages when negative consequences of the act are anticipated. Janis and Mann state that the decision should be psychologically resolved prior to the pregnancy termination or severe postdecisional regret will be experienced.

The five-stage sequence "is intended as a schema for a microanalysis of the positive and negative incentives that enter into a predecisional choice (in Stage 3) and of the new incentives added by social commitments (in Stage 4), all of which

are assumed to influence the long-run stability of the decision (Stage 5)" (Janis & Mann, 1968, p. 335). An unstable decision is easily challenged leading the decision maker back into the conflict mode. Unpleasant tension is the result. Decisions made hastily in crises situations are more vulnerable to challenges (Janis & Mann, 1968), and women in situations where the fetus is diagnosed with an abnormality and the fate of the pregnancy must be determined quickly are in such vulnerable situations.

Following the abortion, the stability of the decision or the resolution of the conflict is hypothesized in this research to influence the intensity of grief postabortion. The unpleasant tension experienced when a conflict is unresolved continues postabortion and negatively affects the woman's grief over the loss of the fetus. Tension and loss are concepts in the University of British Columbia Model for Nursing (Campbell, 1987), which will be described.

University of British Columbia Model for Nursing

The University of British Columbia Model for Nursing (Campbell, 1987) (referred to as the Model) views an individual as a behavioral system made up of nine subsystems: achieving, affective, ego-valuative, excretory, ingestive, protective, reparative, respiratory, and satiative. Each of the nine subsystems is responsible for the satisfaction of one basic human need based on a process in which goal achievement is the outcome. Each subsystem is viewed as a life space as described by Lewin (1935) in his concept of field theory. Major concepts of significance in the Model with relevance to this study are the

concepts of life space, force, tension, and loss.

Life space "represents the relationship of factors and influences (need, abilities, goal, forces) that determine the behaviour of the subsystem at any given moment" (Campbell, 1987, p. 36). Bigge (1982) states that the life space "represents the total pattern of factors or influences that affect an individual's behavior at a certain moment or longer juncture of time" (p. 109). These factors or influences are considered to be positive and negative valences which motivate a person toward or away from a specific goal (Lewin, 1935). In the Model, these valences are termed "forces."

A force is "a determinant of movement toward or away from a goal; forces may arise from the need and abilities of the subsystems (personal); from other behavioural systems (sociocultural); or from the impersonal aspects of a situation (impersonal)" (Campbell, 1987, p. 36). When a woman is deciding to terminate a pregnancy, forces may arise from her personal beliefs or morals in relation to abortion or those beliefs related to disabled persons. She may continue the pregnancy with a defective or potentially defective fetus considering the influence this would have on the meeting of her personal needs. Other behavioral systems may include significant others such as her husband, family members, or other important persons in her life. Impersonal forces could be the lack of personal funds to support a disabled child or society's lack of support for disabled persons. Positive and/or negative forces that are within the woman's life space influence her decision to either

continue or terminate the pregnancy.

A concept discussed in Janis and Mann's (1968) decision-making theory which is a key concept in the Model is tension. Tension, according to the Model is a "need-related sensation that is experienced by a subsystem and varies in intensity with the degree of need satisfaction" (Campbell, 1987, p. 37). The tension is experienced in the predecisional period when the woman anticipates the negative consequences of the decision. Indicators of this tension are sleeplessness, loss of appetite, and loss of sexual interest (Bracken, 1974), and these indicators are again evident after the abortion if the woman suffers from postdecisional regret. This postdecisional tension is compounded by the tension experienced when basic human needs are unmet. For example, need satisfaction may not occur in the achieving, satiative, and/or ego-valuative subsystems due to the losses incurred when the pregnancy is terminated.

According to the Model, loss is "being without that which has or could have had meaning for the individual" (Campbell, 1987, p. 37). Rando (1984) describes two losses which are relevant for the pregnant woman aborting. They are physical losses and symbolic losses. The physical losses would be the actual loss of the fetus and the physical aspects of the pregnancy such as the enlarged breasts and uterus. Symbolic losses would include all "fantasies, needs, hopes, dreams, and expectations placed upon this child-to-be" (p. 57), which would be lost. Another symbolic loss could be the perceived loss of the ability to produce a healthy baby. Rando emphasizes that "each loss must be viewed

from the bereaved person's own frame of reference" (p. 48), which regards the meaning and significance of the particular pregnancy.

Grief, which is not included in the Model, is closely related to the loss concept and is the group of responses indicative of a significant loss. Grief will now be reviewed.

Grief is defined by Carlson (1970) as the "series of emotional responses that follow the perception, or anticipation, of a loss of one or more valued or significant objects" (p. 96). Others, Peppers and Knapp (1980b), Kennell, Slyter, and Klaus (1970), Parkes (1986), Peretz (1970), Lindemann (1944), and Rando (1984) include physical and social responses to loss as well. Peppers and Knapp's list of grief responses includes emotional, physical, and social effects. Emotional or psychological effects, according to Peppers and Knapp, are denial, guilt, resentment, bitterness, depression, time confusion, irritability, sadness, sense of failure, concentration problems, failure to accept reality, and preoccupation with thoughts and memories of the deceased. Physical effects are exhaustion, loss of appetite, sleeping problems, lack of strength, weight loss, headache, blurred vision, breathlessness, and palpitations. The social effects are withdrawal from participation in normal activities, isolation, and possibly, physical separation from the spouse. Although grief reactions vary in intensity and degree, Lindemann, Parkes, Peppers and Knapp, and Peretz have described the typical grief reaction in terms of a specific duration.

Six weeks has been determined as the average length of time for grieving to take place and for a return to the level of

functioning prior to the loss to occur (Lindemann, 1960; Parkes, 1965; Peretz, 1970). However, the psychological reactions such as the mental pain or crying seem not to leave the person entirely. There are times when the person is reminded of the loss and may experience a grief reaction past this six-week period (Peppers & Knapp, 1980b; Parkes, 1965). Peppers and Knapp refer to this as "shadow grief," which does not dominate the person's existance. Caplan (1974) considers a loss as a crisis which may last from four to six weeks; and by the end of that time, the tension abates and there is a return to a steady psychological state. Caplan states there can be either an adaptive (healthy) or maladaptive response to the crisis. "If it is maladaptive, he emerges with a greater vulnerability to mental disorder, which shows itself either in the near future or after similar responses to subsequent crises has taken him still further along the road of irrationality" (Caplan, p. 202). In summary, according to Caplan, a significant loss initiates a disorganization of usual functioning which is self-limited and gradually leads to a reorganization of life.

The University of British Columbia Model for Nursing (Campbell, 1987) and Janis and Mann's (1968) theory of conflict in decision-making provide the framework for this study. Life space, force, tension, and loss are relevant concepts in the Model, and their roles in this study have been described. Although grief is not a concept in the Model, it is closely related to loss and has been reviewed. Janis and Mann's

theory of conflict in decision-making provides the background knowledge necessary to understand the life space of the woman undergoing a pregnancy termination for genetic indications and the determinant forces in her life space, and the unpleasant tension she experiences.

Statement of Purpose

The purpose of this study was to determine if a relationship exists between the degree of maternal conflict experienced in the decision-making process prior to a genetically indicated abortion and the intensity of grief experienced postabortion.

Research Questions

1. What degree of conflict do women experience after the fetal diagnosis is made and prior to the abortion?

2. What intensity of grief do women experience following an abortion for genetic indications?

3. What is the relationship between the degree of conflict and the intensity of grief?

Definition of Terms

1. Abortion for genetic indications - an induced abortion because of a defective or potentially defective fetus (chromosomal anomaly, neural tube defect, skeletal or major organ malformation, teratogen exposure with the potential to affect the fetus)

2. Maternal conflict - a situation where the forces acting on the person are opposite in direction and about equal in strength (Lewin, 1935)

3. Maternal grief - "a highly variable emotional,

psychological, physical, and social response to the loss of a loved one through death" (Peppers & Knapp, 1980b, p. 27)

Assumptions

1. A pregnancy is a complex emotional event in the life of a woman.

2. An abortion for genetic indications is a crisis in the life of a woman.

3. Conflict is experienced in the decision-making process preabortion.

4. Grief is experienced in the postabortion period.

Limitations

1. The generalizability of this study is limited by the fact that all data were collected in one medical genetics department; therefore, any conclusions may be applicable only to this particular population and sample.

2. The small sample size limits the generalizability of the conclusions.

Organization of the Following Chapters

This study report is organized into five chapters. Chapter one has outlined the context of the problem, the conceptual framework, and the purpose of the study. Chapter two presents a review of selected literature on conflict and maternal grief of women aborting for genetic indications. Chapter three describes the research methodology, data collection, and analysis. Chapter four includes the findings and discussions of the findings. A summary is presented in chapter five with recommendations for nursing education, practice, and research.

CHAPTER TWO

Review of Related Literature

Introduction

This literature review has been organized to outline the two major concepts of this study, which are conflict and grief. The first group of studies describes what is known about conflict when women decide to abort a fetus for genetic reasons. The second group of studies describes the grief of women experiencing an elective abortion for genetic reasons.

Conflict

A few studies have been done to study conflict in the decision-making process either before prenatal diagnosis was done or before the abortion. The findings in all these studies concluded that the decision to abort was not easy because of the personal dilemma of wanting a child and moral beliefs about abortion and disabled persons. The women considered the burden of bearing a defective child and the burden on society as well.

Davies and Doran (1982) interviewed women seeking antenatal genetic counselling because of their advanced maternal age to identify the factors involved in their decision to seek counselling. The sample included 66 women who had amniocentesis. Eighty-nine percent of the 66 women sought prenatal counselling because of their age and the possible risks associated with advanced maternal on the development of the child. The women perceived having a Down's syndrome child as being a burden on their personal lives and a burden on society. Their personal finances were also considered. Thirty-one percent were concerned

about the affected child's well-being. Fifty-three percent anticipated that the decision to abort would be difficult. The two major reasons expressed by these women that made the decision difficult were moral beliefs and a desire for a child. For a few, fetal movement made the decision difficult. A large number had a religious affiliation, but the women reported they were not influenced by this affiliation.

Finley, Varner, Vinson, and Finley (1977) studied women who had either continued or terminated their pregnancies after having prenatal diagnosis. One hundred fifty-seven of 196 women completed the questionnaire. Ten women had positive prenatal diagnoses. The researchers found that one of the major concerns of women prior to amniocentesis was the possibility of having to make a decision about abortion. Forty-nine percent were concerned about having to make this decision. If they were to have the test again, 46% responded that they would be concerned about deciding on abortion. Seventy-one percent planned on ending the pregnancy if the test results were positive; 6% would not have an abortion; and 23% were undecided.

Robinson, Tennes, and Robinson (1975) studied women one year after amniocentesis to better understand the emotional aspects of the experience. Thirty-three women were asked to participate, but only 22 did. The subjects were interviewed with open-ended questions. Generally, the researchers concluded that none of the women took the abortion issue lightly. On a personal level, the women considered the burden of having a defective child on their lives, marriages, and families. They considered their own and

the family's ability to cope with a defective child, and the social, financial, and physical stresses of having a disabled child in the family. From a societal perspective, some women were influenced by an "unwillingness knowingly to bring a defective child into the world" (Robinson et al, p. 103). Attitudes towards a repeat amniocentesis were favorable. Twenty would repeat and three recommended amniocentesis to their friends. A weakness of the study, which the researchers acknowledged, was the unknown responses of the nine who did not participate.

Furlong and Black (1984) explored the experiences and coping strategies of families of women who terminated a pregnancy following detection of a serious defect in the fetus. The focus of the study was on the family, particularly siblings, but data uncovered issues experienced by the parents related to decision making. The researchers conducted semi-structured interviews on a small convenience sample of 15 families. For the parents questioned, the abortion represented a painful and serious episode in their lives. All couples reported that there was agreement on the decision to abort, but between mothers and fathers there was a difference on rating the difficulty of the decision-making experience. Nine of the fifteen mothers reported that the decision was difficult, and one reported it was at least somewhat difficult. Two of the six fathers felt the decision was difficult, and four said it had not been difficult. Comments suggested that dilemmas experienced by the parents stemmed from personal dilemmas rather than uncertainty and confusion about the

fetal diagnoses or prognoses.

Fletcher (1972) interviewed 25 couples to determine the ethical issues parents experienced when they have prenatal diagnosis and genetic counselling. He described two sources of human conflict which existed. They were: first, the inner conflict within the person and second, the conflict between self and community. The first source of conflict would arise amongst the inner loyalties to self, family, and the unborn child; the second source of conflict would arise between the person and the significant community (for example, the church). Moral suffering ensued when the parents wanted a child desperately, but not a defective child. Flether stated that the parents were "caught between the rightness of protecting their families from the great strains which genetic disease ... [placed] upon them, and the rightness of unconditional caring for the life of their conceived child " (p. 479).

Grief

A variety of responses to the loss of a defective or potentially defective fetus have been documented in the literature. Some responses included depression, social disruption, guilt, and acute grief. These responses were but a few of the characteristics of the classic grief reaction described by Parkes (1986) and Lindemann (1944).

Donnai, Charles, and Harris (1981) conducted an exploratory study using unstructured interviews to elicit data on the psychological and social reactions of those undergoing termination of pregnancy for genetic reasons. The convenience

sample consisted of twelve women. The researchers concluded "that the small numbers of women undergoing termination of a planned or wanted pregnancy after prenatal diagnosis ... [constitued] a high risk group, vulnerable to depression and social disruption" (p. 622). However, this stated conclusion did not seem to be consistent with the data. When interviewed, seven patients reported a good emotional recovery; three considered the recovery fair; and two continued to be troubled by "a disturbing and distressing reaction" (p. 622). All subjects found the interview an emotional strain. Although the study was anecdotal, it did support the notion that psychological sequelae, either minimal or severe, did exist.

Blumberg, Golbus and Hanson (1975) studied 13 couples following abortion for genetic reasons using psychometric testing and psychiatric interviews. The purpose was to determine if the couples were at risk for psychological trauma following the abortion. The researchers stated that the women experienced a high incidence of depression (92%), which was greater than that usually associated with elective abortion for psychosocial indications or with delivery of a stillborn. The comparisons were made to research findings in separate studies. The methods used to collect data were interviews with open-ended questions and the Minnesota Multiphasic Personality Inventory (M.M.P.I.), which evaluated individual personality status and emotional adjustment. Data from case histories, M.M.P.I.s, and interviews were analyzed resulting in preliminary findings suggesting there was a high incidence of psychological trauma. Depression,

guilt, undesirable marital consequences such as separation, and "flash-backs" of emotions were related to the experience.

Lloyd and Laurence (1985) did a retrospective study to examine the sequelae and support after termination of pregnancy for fetal malformation. Forty-eight women were interviewed at home immediately after the termination, at six weeks, and at six months after the termination. Seventy-seven percent of the sample suffered an acute grief reaction. The six-month interviews revealed that 46% were symptomatic. Symptomatic meant the women required psychiatric support.

Jones et al (1984) interviewed 12 couples plus two women who had a midtrimester therapeutic abortion following an amniocentesis to discover individual responses as well as perceptions to the process of pregnancy, amniocentesis, therapeutic abortion, and sequelae. Generally, the results indicated the respondents coped well with the experience. Seventy percent of the couples described their marital relationship as closer and few suffered long-term deleterious effects. The researchers suggested that the study results may not be accurate considering the sample size and attrition. Of 36 couples invited to participate, 4 relocated, 9 declined, and 9 were unavailable for follow-up. Only 2 women plus 12 couples remained in the study. The differences between the sample and the decliners, relocaters, and those unavailable for follow-up were unknown. The researchers suggested "the possibility that couples who ... [agreed] to participate may have fewer conflicts and less emotional trauma in their lives than those who declined

participation" (p. 255).

Summary

The literature review has explored what is known about conflict and grief as experienced by women aborting for genetic indications. Several studies researched conflict for those who have prenatal diagnosis and those who terminate pregnancies for genetic reasons. All studies supported the idea that grief postabortion for genetic indications did exist. Further research is needed to learn about conflict preabortion and grief postabortion and the relationship between the two concepts.

CHAPTER THREE

Methodology

Introduction

This descriptive, correlational study was designed to describe the relationship between conflict and grief. The research questions guiding the study methodology included: 1) What degree of conflict do women experience after the fetal diagnosis is made and prior to the decision to abort? 2) What intensity of grief do women experience following an abortion for genetic indications? and 3) What is the relationship between the degree of conflict and the intensity of grief? This chapter will discuss the process for obtaining study participants, the instruments, and the methods of data analysis. Ethical considerations and mechanisms for the protection of human rights will be presented.

Process of Obtaining Study Participants

A convenience sample of nine women who met the following criteria comprised the sample for this study. The woman had to have had an induced abortion because of a fetal anomaly or the potential to have a fetal anomaly. The woman's pregnancy could be of any gestational age. The woman had to be able to read and write English.

Initial contact with potential participants was made through the medical genetics department in a major urban hospital. A staff person identified suitable candidates who met the sample criteria. The information letter (Appendix A) and the consent to participate (Appendix B) were given to the woman when

she was in the medical genetics department. A self-addressed, stamped envelope was enclosed so the woman could read and sign the consent at home and then return it to the researcher. The questionnaire (Appendix C) was mailed to each consenting participant six weeks postabortion to be completed in its entirety then.

At first, there were few respondents and it was felt that at initial contact the woman might have been too distraught to sign the consent to participate. So, potential respondents were asked to sign a consent to be contacted (Appendix D). This appeared to be acceptable to both the staff approaching the women and the women themselves. It took six months for nine subjects to volunteer and complete the questionnaires.

Instruments

The questionnaire (Appendix C) had three parts. The first part collected demographic information and an obstetrical history; the second part collected data on conflict; the third part collected data on grief intensity.

To measure conflict, a scale designed by Bracken (1974) was used. This scale was designed to determine if conflict was an intra-psychic process delaying women's decision to abort for personal reasons. The original study population included 328 women, both blacks and whites, presenting themselves to private abortion clinics in New York and New Haven. The results of Bracken's study concluded that those women with increased conflict delayed in seeking an abortion.

Bracken (1974) did some reliability testing when he first

designed the scale. To measure internal consistency, he did intercorrelations of variables in the conflict scale with the overall conflict score. The correlations ranged from .52 to .79 (happy-sad, .52; times changed mind about the abortion, .62; killing-not killing, .52; accept-reject, .67; relief-distress, .78; ease of abortion decision, .79). Comparing the questions with personal observations and anecdotal and research-based literature, the questions had content validity.

Bracken (1974) used a seven-point semantic differential technique to measure the degree of conflict. The conflict score was the mean score of the response to six items (Appendix C) and ranged from a low conflict score of 1.0 to a high of 7.0. Women were considered to be in a high state of conflict if they reported being initially very happy about the pregnancy, distressed over and initially rejected the abortion, felt that they were killing their child, had difficulty deciding, and frequently changed their minds. Because of the present debate over the status of the fetus in terms of personhood and the emotionality of this debate (Beauchamp & Walters, 1982), the wording of the question on killing or not killing the child was changed. The changed wording reflected the intent of the original question, but released the question of the criminal intent of "killing" attached to it. The question then read: "Do you think an unborn fetus is or is not a person?" No other changes to the questions on conflict were made.

To measure internal consistency of the conflict scale in the current study, each item's score was intercorrelated with the

overall conflict score excluding the item being tested. The correlations ranged from 0.112 to 0.698 (happy-sad, 0.419; relief-distress, 0.112; accept-reject, 0.662; person-not a person, 0.505; ease of abortion decision, 0.674; times changed mind about the abortion, 0.698). The second question on the first reaction to the thought of terminating the pregnancy being either relief or distress was discarded in determining the overall discrimination index because of its low value. The Hoyt estimate of reliability was finally determined to be 0.95. The Hoyt estimate of reliability is an estimate of homogeneity of the items in the test which examines the extent to which all the items in the instrument measure the same construct (Devore & Peck, 1986). The wording of the question on the status of the fetus had been changed in the current questionnaire, but did not appear to affect the responses when compared to Bracken's reliability score, which was 0.52 compared to 0.674 in the current study.

To measure grief, an 18 item Grief Intensity Scale designed by Peppers and Knapp (1980a) was used (Appendix C). The scale expanded on the research done by Kennell, Slyter, and Klaus (1970) in the development of a grief score. Kennell et al interviewed women who had experienced a neonatal death. They discovered six variables which were part of the grieving process--sadness, loss of appetite, inability to sleep, irritability, preoccupation, and inability to return to normal activity. After reviewing the literature on grieving, Peppers and Knapp expanded the questionnaire to include other emotional,

psychological, physical, and social responses. The scale directed the subjects to rate themselves on a scale from 1 (no problem) to 9 (extreme difficulty) on each variable yielding scores ranging from 18-162. The women were asked to rate their grief immediately after the loss and some time after the loss. This time ranged from 6 months to 36 years with a mean of 8.1 years and a median of 5.9 years.

The Grief Intensity Scale had been used in numerous studies, but little data on reliability and validity were available (McCall, 1988). McCall used the scale to measure grief intensity for a study population consisting of 15 women who had experienced miscarriage. Prior to using the scale, McCall determined the alpha coefficients to be .88 and .81 giving the scale a high internal reliability. Comparing the items in the questionnaire with personal observations and anecdotal and research-based literature on the topic, the questions had content validity.

The reliability of the questionnaire in the present study was examined after the subjects returned the questionnaires. The Hoyt estimate of reliability was finally determined to be 0.96. Three of the eighteen items in the questionnaire had low or negative discrimination indices when compared with the overall grief score excluding the items anlyzed; therefore, these scores were discarded. The items discarded were eight, twelve, and thirteen. The remaining discrimination indices were as follows: the sadness item was 0.683; loss of appetite, 0.896; irritability, 0.766; sleeping problems, 0.914; difficulty concentrating, 0.834; preoccupation with thoughts and memories of

your child, 0.703; depression, 0.857; anger, 0.806; guilt, 0.821; problems returning to usual activity, 0.926; time confusion, 0.887; repetitive dreams about the baby, 0.870; exhaustion, 0.903; lack of strength, 0.858; wondering about what went wrong, 0.403.

Data Analysis

The demographic information and obstetrical history gathered from the questionnaire was used to describe the sample's characteristics.

Research questions 1 and 2. The conflict and grief intensity scale from each participant was calculated and examined for frequency distribution, and measures of central tendency and variability.

Research question 3. Since the sample was small and distribution free, the relationship between conflict and grief was analyzed by plotting grief against conflict on a scatter plot. The scatter plot provided an informative picture of the bivariate numerical data (conflict and grief) to determine the possible relationship of the variables (Devore & Peck, 1986).

Ethics and Human Rights

The rights of participants were safeguarded in the following ways.

Confidentiality was maintained. Each participant's name and a code were listed. Code numbers were placed on questionnaires that the research participants completed. The list with the names and codes were destroyed when the study was complete. At no time did names appear or will they appear in any published or

unpublished material. Data were reviewed only by the investigator.

An informed consent was obtained prior to data collection. The letter of information described the study and the subject's role in the study. The study participant was given the opportunity to question the researcher about the study.

The principle of autonomy was maintained for the subject. If at anytime the subject wished to withdraw from the study, she could do so. The subject was reminded that her actions regarding the study would not jeopardize any health care being received by her or other related persons.

Summary

The methodology used in this descriptive, correlational study involved two data collection instruments. Each tool added information to the data base which was then analyzed according to established statistical methods. Ethical and human rights were also discussed.

CHAPTER FOUR

Presentation and Discussion of the Findings

Introduction

This chapter is divided into four sections. The first section describes the characteristics of the study participants. The next three sections present an analysis of the data responding to the three research questions. Each section is followed immediately by a discussion.

The Study Participants

Age, Marital, and Educational Status

The sample consisted of nine women whose average age was 33.4. The ages ranged from 25 to 42 years. The median was 35 years. Eight of the subjects were married with one in a common-law relationship. Education levels varied from highschool (44%), to postsecondary (33%), and university education (22%).

Past Obstetrical History

All but one of the subjects had a previous pregnancy, and a large percentage (66%) had experienced previous pregnancy losses. Six out of nine (66%) had an elective abortion; two out of nine (22%) had a miscarriage; and two out of nine (22%) had a child die. Whether or not this was a prenatal death was not determined. Three women (33%) had experienced several previous losses (miscarriage, death, and/or elective abortion). Five (55%) had children living at home with them. One woman (11%) had a history of difficulty getting pregnant in previous pregnancies.

Characteristics of This Pregnancy

Eight of the nine pregnancies were planned (88%). All

respondents denied any difficulty achieving pregnancy this time. Four out of nine (44%) had felt fetal movement. The average time when the women discovered they were pregnant was six weeks. The women either suspected they were pregnant or had the pregnancy medically confirmed at that time.

The number of days between the day the subjects were told something was wrong with the fetus and the date of the pregnancy termination ranged from two to twenty days. The average length of time was 11.9 days with a median of 7 days. The average time for the pregnancy termination was 18.3 weeks with the range from 13 to 27 weeks and the median 18.5 weeks.

All subjects had an ultrasound done. Ultrasound testing was the primary diagnostic tool for five out of nine (55.5%) subjects. Two (22.2%) had chorionic villi sampling followed by an amniocentesis. Three (33.3%) had only chorionic villi sampling done.

Research Question One: What degree of conflict do women experience after the fetal diagnosis is made and prior to the abortion?

To determine the degree of conflict experienced in the decision-making process prior to the pregnancy termination, a conflict scale developed by Bracken (1974) was used. The subjects were sent the questionnaires six weeks posttermination and asked to judge their conflict retrospectively. The conflict score for the current study was 23.88 with a standard deviation of 8.04. The lowest score was 14.00 and the highest score was 35.00. The lowest score obtainable was 5, and the highest was

35.

Comparing the current study results to Bracken's (1974) study results, the conflict scores were similar. Bracken's study population included women aborting for personal reasons. Bracken's average conflict score was 25.0, which he considered to be high. Bracken's results indicated there was a greater level of conflict associated with second trimester abortions with a decline in conflict at 18 weeks gestation. The time of pregnancy terminations in the currect study averaged 18.3 weeks with a median of 18.5 weeks.

Sjögren and Uddenberg (1988) supported the idea of conflict in decision making during prenatal diagnosis. The researchers provided evidence that considerable deliberation happened before having prenatal diagnosis; however, this did not discourage the women from having prenatal testing done. Many of the women in Sjogren and Uddenberg's study postponed the decision to have a legal abortion until they had reviewed the test results. One woman had commented that she was sure she would abort a defective fetus but hesitated when she saw signs of life on the ultrasound screen. An interesting finding in Sjögren and Uddenberg's study was the lack of autonomy the women had in deciding to proceed with prenatal diagnosis. Although the women felt free to undergo prenatal diagnosis, they considered it difficult to refrain from prenatal diagnosis when it was offered. Sjögren and Uddenberg suggest that society demands that women use prenatal diagnosis and abort defective fetuses to save society the responsibility of caring for a disabled child. Furthermore, Sjögren and

Uddenberg's results indicated "that the decision making, even if it may seem rather easy, is often characterized by deliberation and ambivalence (p. 222)."

The ethical and moral issues surrounding pregnancy terminations for genetic reasons affect the conflict experienced. The ethical issues of selective abortion discriminating against the disabled (Smith, 1981; Sjögren & Uddenberg, 1988) and violating fetal rights (Dyck, 1971; Aumann, 1988) might have been difficult to handle in the decision-making process. Moral and ethical issues may be clouded when the woman's religious beliefs are considered in the process of decision-making.

Decision making may be made difficult when the results of prenatal diagnosis are not black and white. Ambiguity about the diagnosis may cause anxiety such as in the situation where an extra Y chromosome is present (Beeson, Douglas, Lunsford, 1983). Only one participant stated that there would be no chance for her fetus to survive; and her conflict score was above the average and her grief score was average.

Research Question Two: What intensity of grief do women experience following an abortion for genetic reasons?

To determine the intensity of maternal grief posttermination, the grief measurement scale designed by Peppers and Knapp (1980a) was used. The subjects were sent the questionnaires six weeks after the termination and asked to complete the questionnaires to determine their grief intensity at that time. Descriptive statistics were used to analyze the data. The average number of grief points was 61.44 with a standard

deviation of 33.69. The range was 30 to 133. The lowest score possible was 15, and the highest score was 135.

Peppers and Knapp (1980a) and McCall (1988) were the only published studies using the grief intensity scale designed by Peppers and Knapp. Peppers and Knapp's study population included those women who experienced miscarriages, stillbirths, and neonatal deaths. Peppers and Knapp asked women who had experienced a perinatal death to score their grief retrospectively when they had the pregnancy loss and presently. The time after the loss was from six months to 36 years with an average of 8.1 years. The current study's results were higher six weeks posttermination than the later results collected six months to 36 years.

In McCalls' (1988) study, the grief intensity scores ranged from 28 to 118 points (median 58, average 62.9, standard deviation 26.7) at the time of miscarriage. Four to six weeks later the scores were significantly different (median 28, average 32.6, standard deviation 12.4). The grief points in the current study were greater six weeks after loss than those points determined six to ten weeks after miscarriage in McCall's study.

The average grief score for the current study was high and may be related to gestational age. The average gestational age was 18.3 weeks when the pregnancy was terminated. Toedter, Lasker, and Alhadeff (1988) did a longitudinal study to determine the factors affecting grief resolution following spontaneous abortion, fetal or neonatal death, or ectopic pregnancy and determined that the greater the gestational age the more grief

experienced. Kirkley-Best (1981) studied prenatal bereavement and Theut et al (1989) studied perinatal bereavement in women who had experienced miscarriages, stillbirths, and neonatal deaths and also found evidence to support the positive relationship of increased gestational age and grief. Peppers and Knapp (1980a) found no difference in the grief scores of women experiencing miscarriages, stillbirths, or neonatal deaths; however the scores were gathered up to 36 years after the loss event. Theut et al speculate that "perhaps bereavement for early loss and bereavement for late loss become indistinguishable over time (p. 638)." Of the studies cited and the current study, there was more grief experienced for later losses.

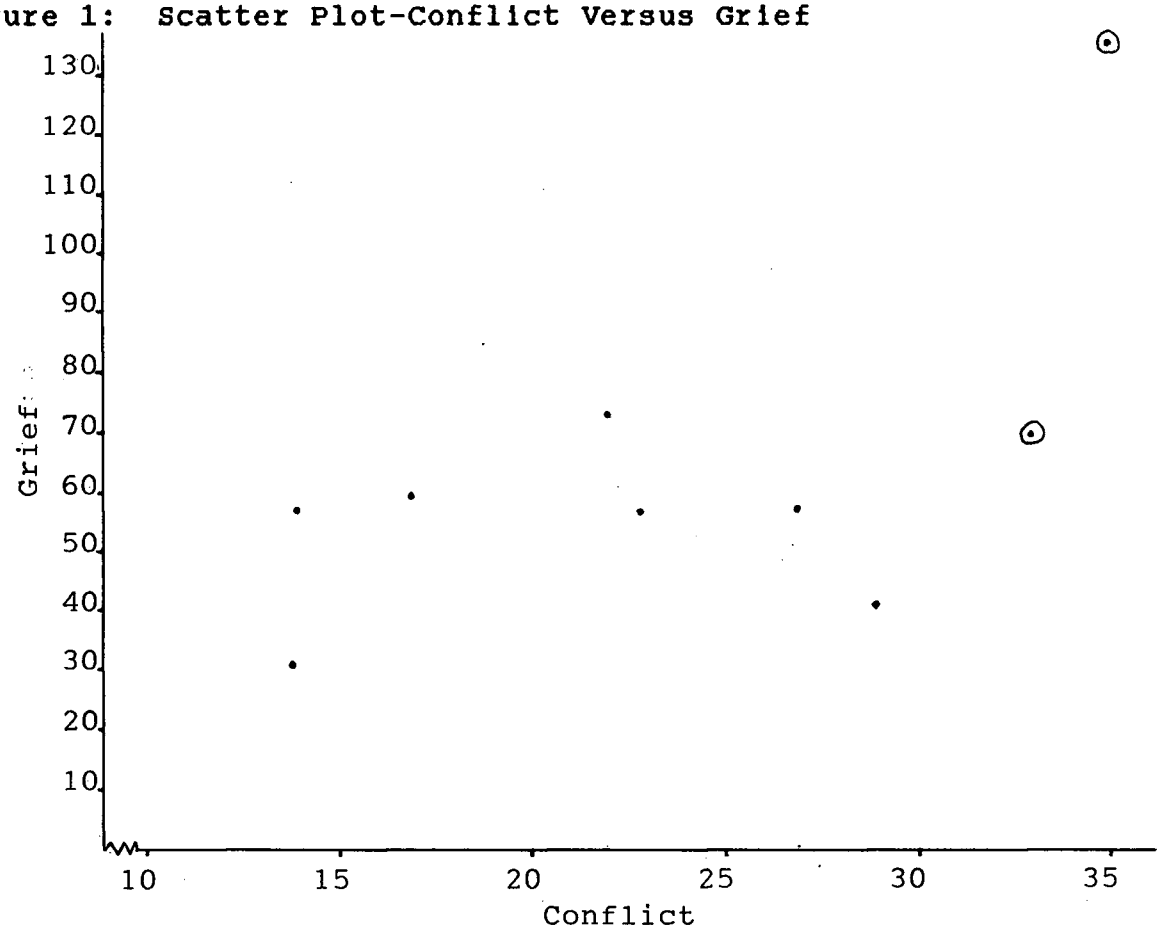
The high grief scores in the current study could be related to the later age of the women (the average age was 33 years) and the fact that for four of the nine women (44%) this was their first planned pregnancy. Silvestre and Fresco (1980) studied the reactions of older women to prenatal diagnosis. More than half were expecting their first child and expressed how precious the child was considering their advancement towards infertility. These women did not experience the pregnancy as real until after the results of the tests were known. Then they announced the pregnancy and some said they even felt the fetus after the test, but not before. Mansfield and Cohn (1986) further discussed the dysfunctional stress that older women experienced because they failed to follow traditional youthful childbearing. The question remains whether or not impending infertility related to increasing age or the dysfunctional stress felt by older women

influenced the grief these women experienced in the current study.

Question Three: What is the relationship between the degree of conflict and the intensity of grief?

The grief and conflict scores were paired and plotted on a scatter diagram. The scatter plot showed a curvilinear relationship with grief increasing, reaching a plateau and then decreasing as the conflict score went up (see Figure 1). Two outliers appeared in the plot (circled). The extreme outlier experienced a high intensity of grief and a high degree of conflict (conflict=35, grief=133). The other outlier (conflict=35, grief=63) did not experience the intense grief.

Figure 1: Scatter Plot-Conflict Versus Grief



A review of the characteristics of the subjects who were located in the lower, outer quadrant revealed that they had experienced previous losses and/or had children already. Three of the subjects had previous pregnancy losses (two had deaths, age not specified; two had miscarriages; three had elective abortions [some subjects experienced all or some of the losses]). Kirkley-Best (1981) in her exploratory study on prenatal bereavement found that previous reproductive failure was not associated with more intense grief. Benfield, Leib, and Vollman (1978) and Toedtler, Lasker, and Alhadeff (1988) found evidence to support the idea that previous loss was not a key variable in predicting the intensity of grief. Perhaps in the current study, past reproductive failure may have dampened the posttermination grief because the women had experience in dealing with a significant loss and could more easily deal with the present loss.

Four of the subjects in the lower, outer quadrant had live children, and perhaps this was the variable that lessened the grief even though the conflict remained high. A common belief is that already having children makes a loss easier to handle, and that "parents know ... they are capable of childbearing and they have their other child or children to comfort and distract them (Toedter, Lasker, Alhadeff, 1988)." Kirkley-Best (1981), Toedter et al, and LaRoche et al (1984) all provided evidence to support the idea that previous births were associated with lower grief scores.

Summary

This chapter began with a description of the study population. There were nine women who aborted for genetic reasons in the sample. The first question on the degree of conflict was answered, and the degree of conflict was found to be high. The amount of conflict measured in other similar studies was comparable and supportive of the current study's findings. The second question on the intensity of grief was answered, and the grief was found to be high. A comparison of the current study's results with others on perinatal grief indicated that grief was comparable to that experienced after a stillbirth and/or neonatal death and greater than that experienced in an early pregnancy loss (miscarriage). A curvilinear relationship was apparent on the scatter diagram when grief was plotted against conflict. Those women who experienced higher conflict and lower grief had previous losses and/or a child or children.

CHAPTER 5

Summary, Recommendations for Nursing Education, Practice, and Research

Introduction

This chapter concludes the presentation of the study. The chapter begins with a summary of the study and the findings. Recommendations for nursing education and practice follow focussing on counselling as an independent function of nursing and the application of this function in clinical practice. Finally, recommendations for nursing research are made.

Summary of the Study

This descriptive, correlational study was designed to determine the amount of conflict women experienced prior to aborting for genetic reasons, the amount of grief these women experienced six weeks after the abortion, and if there was a relationship between the conflict and grief. The sample consisted of nine women who aborted their genetically defective fetuses in the second trimester. The sample participants were initially approached by staff members in a medical genetics department of a large urban hospital to obtain their consent to participate. The participants were referred to the department by their family practitioners.

Conflict was identified as the independent variable to study which could affect the dependent variable grief. Conflict was identified in the literature as one of the variables complicating the decision-making process prior to the termination of a pregnancy. It was hypothesized that pretermination conflict

would affect the grief experienced by women posttermination.

Data were gathered by questionnaires. The questionnaires were mailed to consenting subjects six weeks posttermination. Data were collected on conflict in the decision-making process preceding the termination retrospectively and grief experienced six weeks posttermination.

To answer the three research questions, summary statistics were used. The answer to the first question revealed that a high conflict level did exist. The degree of conflict was compared to the degree of conflict experienced by women aborting for personal or social reasons and for genetic reasons and found to be comparable. The answer to the second research question revealed that the women experienced a moderate to high intensity of grief six weeks posttermination. Comparing this amount of grief with other studies revealed that these women grieved more six weeks after the loss than those who experienced miscarriages; and the women experienced the same amount of grief as those who experienced fetal deaths and/or stillbirths. The answer to the third research question was noted on the scatter diagram when a curvilinear relationship was evident when conflict was plotted against grief.

Recommendations for Nursing Education and Practice

As stated earlier, there is an increase in the number of women presenting for fetal diagnosis with a corresponding increase in women terminating pregnancies for genetic reasons. These women do experience conflict in the decision-making process and do experience a moderate to high intensity of grief

posttermination. The results of this study can direct nursing education and nursing practice.

The recommendations for nursing education are in the development of counselling as an independent function of nursing. Students need to know how to accurately assess those in need of counselling. The students could learn to skillfully counsel those who are grieving and recognize those who have experienced a loss and who are at risk of not returning to a balanced state. Students could learn to counsel those who are having difficulty achieving a decision when conflict exists amongst the alternatives of action. Nursing students could begin by learning basic skills in communication, then learn the basic skills of counselling, and then learn the process of decision-making. A nurse should know the basic skills of counselling and the process of decision-making under conflict to be able to independently counsel clients who are grieving and involved in ethical dilemmas.

A prerequisite to counselling clients who are electively terminating pregnancies because of fetal anomalies is an understanding of philosophical reasoning. Ethical problems and dilemmas are common in maternal-child nursing because of the advancements in technology. The nurse should have knowledge of ethics and philosophy prior to counselling those clients who are involved in decisions about parents as ultimate decision makers, elective termination of pregnancy, and the rights of fetuses as persons (Archer-Dusté, 1988).

The recommendations for nursing practice are applying those

counselling skills learned in nursing education in the care of clients aborting for genetic reasons. Grief counselling should continue for more than six weeks posttermination until the client achieves a steady psychological, social, and physical state. When resources are limited, phone interviews can be done; or if resources are not limited, face-to-face interviews can be done (Ilse & Blackburn Furrh, 1988). Support groups can be formed for this type of client. Objective counselling prior to the pregnancy termination should be implemented for all women, and the counselling should be of a length of time that allows a quality decision to be made. A quality decision is one where all steps in the decision-making process have been worked through (Janis & Mann, 1968), and the decison to abort is internally derived rather than externally derived (VanPutte, 1988).

Pre- and posttermination programs in the form of individual and group counselling and education need to be expanded to accommodate the increasing numbers of women having prenatal diagnosis and pregnancy termination. The changing demographics of childbearing plus the trend to do maternal serum alpha-fetoprotein screening at 15 to 20 weeks will strain the existing resources of medical genetics centres (Myhre, Richards, & Johnson, 1988).

Recommendations for Nursing Research

The number of study participants in this study was small; therefore, the significance of the results is questionable and the generalizability limited. Increasing the number of participants in such a study would provide more information on the nature of the

relationship between conflict and grief. If a curvilinear relationship could be supported with more participants, research could be done on those participants who experienced a lower intensity of grief and a higher degree of conflict. They could be interviewed to determine why the higher degree of conflict was related to a lower intensity of grief. The characteristics of those who experienced high conflict and low grief could be examined in greater detail and with larger numbers to reveal why this phenomenum occurred.

Other variables could be examined to determine their effect on the grief experienced posttermination. For example, previous losses such as of children, perinatal losses, and infertility could be studied. The inability to produce a healthy baby may be considered a loss which intensifies the grief experienced. Also, the difference between first, second, and third trimester terminations could affect the intensity of grief experienced when one considers the significance of attachment.

Silvestre and Fresco (1980) concluded that women did not experience the pregnancy until after prenatal tests confirmed a healthy fetus. Is attachment minimized with women who carry a defective or potentially defective fetus? If attachment is minimized, what other variables(s) intervene to intensify the grief after termination?

A longitudinal study could be done to determine the time line for the resolution of grief following a significant pregnancy loss. Grief could be measured at the time of the termination, six weeks posttermination, and then at six months.

These results could then be compared to other study populations who experience significant losses.

The process of decision-making could be more clearly described. Janis and Mann (1977) described the process of decision-making and the criteria for achieving a quality decision. More research on the unique situation of women aborting for genetic reasons may clarify the social and psychological phenomena these women experience and then generate theory relevant to the practice of nursing (Chenitz & Swanson, 1986).

The grief and conflict questionnaires could be further tested to improve their reliability and validity; and therefore, promote the reliability and validity of future studies using these measurement tools.. The discrimination indices were 0.76 and 0.96 for conflict and grief respectively. Both indices are high, but items were discarded because they had low values when correlated with the overall scores minus the particular item being examined.

Very little research has been done on the women, men, and their families who experience a positive prenatal diagnosis. As mentioned, the process, the variables, and the outcomes of the experience need to be studied to provide information to guide health care professionals. Once the knowledge is gained, then nurse educators can prepare students for practice, and nurses can provide appropriate and effective care to this particular population.

Summary

Women aborting fetuses for genetic reasons do experience conflict in the decision-making process and do experience a moderate to high intensity of grief. To enhance the nursing care these women receive, nurses should become skillful counsellors. As well, health care can be improved for this particular population when more research is done to better understand their experience.

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Code Number: _____

Part I: Demographic and Health Information

1. Age:_____

2. Education:
   _____1. grade school completed
   _____2. high school completed
   _____3. post secondary education completed
   _____4. university completed

3. Social:
   Are you married?_____single?_____divorced/separated?_____

4. Obstetrical history (other pregnancies, not including this one):
   a. How many times have you been pregnant?_____
   b. How many children do you have?_____
      Were any adopted out?_____yes_____no If yes, how many?_____
      Have any of your children died?_____yes_____no If yes, how many?_____
      Have you had any miscarriages?_____yes_____no If yes, how many?_____
      Have you had any therapeutic abortions?_____yes_____no If yes, how many?_____
   c. Do you have a history of difficulty getting pregnant?_____yes_____no

5. <u>This pregnancy</u>:
   a. _____planned_____unplanned
   b. Did you have difficulty getting pregnant this time?_____yes_____no. If yes, did you seek medical care or have medical treatment?_____yes_____no.
   c. How many weeks pregnant were you when you found out you were pregnant (either suspected or confirmed)?_____
   d. Did you feel your baby move?_____yes_____no
   e. Which of the following test(s) did you have?
      ____ultrasound
      ____amniocentesis
      ____chorionic villi sampling
      ____maternal serum alpha fetoprotein (a blood test for spinal cord problems)
   f. What is your understanding of what was wrong with your baby?_____

      _____

   g. How many days were there between the day you were told there was something wrong with this baby and the day you ended this pregnancy?

      _____

   h. How far along were you when this pregnancy was ended?_____

      _____

Code Number: _____

Part II: Conflict

Please consider each of these questions by thinking back to the time when your baby was diagnosed as having a problem, and you were deciding whether to continue or end your pregnancy.

Try to relate these questions by circling the number which indicates the best answer.

1. How did you feel when you first suspected you were pregnant?

Happy sad

1------2------3------4------5------6------7

2. What was your first reaction to the thought of terminating the pregnancy?

Relief Distress

1------2------3------4------5------6------7

Rejected Idea Accepted Idea

1------2------3------4------5------6------7

3. What do you think about the status of an unborn fetus?

An unborn fetus is not a person — An unborn fetus is a person

1------2------3------4------5------6------7

4. When you were thinking about terminating the pregnancy, how would you say the decision was for you?

extremely easy — extremely difficult

1------2------3------4------5------6------7

5. Circle the number of times you changed your mind about the pregnancy termination.

1 never
3 once or twice
5 many times
7 all the time

Code Number: _____ **Part III: Grief**

The following are some words and phrases that describe various kinds of reactions that a person may experience after suffering a loss similar to yours.

Try to rate yourself on these reactions by circling the number which most nearly corresponds to the intensity of your feelings as you feel now.

1. SADNESS
no sadness moderate very sad
1----2----3----4----5----6----7----8----9

2. LOSS OF APPETITE
no loss moderate severe loss
1----2----3----4----5----6----7----8----9

3. IRRITABILITY
none moderate much
1----2----3----4----5----6----7----8----9

4. SLEEPING PROBLEMS
no problem moderate severe problems
1----2----3----4----5----6----7----8----9

5. DIFFICULTY CONCENTRATING
no difficulty moderate great difficulty
1----2----3----4----5----6----7----8----9

6. PREOCCUPATION WITH THOUGHTS AND MEMORIES OF YOUR CHILD
no thoughts moderate many thoughts
1----2----3----4----5----6----7----8----9

7. DEPRESSION
none moderate severe
1----2----3----4----5----6----7----8----9

8. FEAR OF BEING ALONE IN HOUSE
no fear moderate great fear
1----2----3----4----5----6----7----8----9

9. ANGER
no anger moderate severe anger
1----2----3----4----5----6----7----8----9

10. GUILT
no guilt moderate severe guilt
1----2----3----4----5----6----7----8----9

11. PROBLEMS RETURNING TO USUAL ACTIVITY
no problem moderate severe problem
1----2----3----4----5----6----7----8----9

12. AFRAID OF RESPONSIBILITY OF CARING FOR CHILDREN
no fear moderate great fear
1----2----3----4----5----6----7----8----9

13. FAILURE TO ACCEPT REALITY
accepted moderate failure severe failure
1----2----3----4----5----6----7----8----9

14. TIME CONFUSION
no confusion moderate severe confusion
1----2----3----4----5----6----7----8----9

15. REPETITIVE DREAMS ABOUT BABY
no dreams moderate many dreams
1----2----3----4----5----6----7----8----9

16. EXHAUSTION
no exhaustion moderate severe exhaustion
1----2----3----4----5----6----7----8----9

17. LACK OF STRENGTH
no lack moderate lack severe lack
1----2----3----4----5----6----7----8----9

18. WONDERING ABOUT WHAT WENT WRONG
no thoughts moderate many thoughts
1----2----3----4----5----6----7----8----9

Appendix D

Consent to be Contacted

You have just been told about a research project studying women having a pregnancy termination such as you are having. If you sign this form, I will phone you and inform you of details of the project. Signing this form does not mean you have to participate in the study, but gives your consent for me to contact you by phone. Participation does include filling out a short, 15-minute questionnaire six weeks after the pregnancy termination.

Thank you.

Jane Mighton, BN, BSN

Name(print):_____

Name(signature):_____

Phone number:_____