A Psychotherapeutic exploration of the presenting issues of Irish women post abortion

By

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Abstract

This research used a psychotherapeutic perspective to gain a more insightful understanding of the Irish woman's subjective experience, particularly considering the issues of stigma, culture, travel to another country and societal attitudes that may affect her. Five separate semi-structured interviews were conducted with one male and four female participants who are practising and accredited therapists from integrative / humanistic orientations. Interview transcripts were analysed using qualitative thematic analysis. Three superordinate themes emerged, the findings of which suggest that instances such as stigma, cultural attitudes, enforced secrecy and a lack of perceived support are factors that influence the Irish woman's abortion experience and contribute to subsequent negative emotional responses. Significantly the findings suggest that it is these factors, not the abortion *per se* that may contribute to psychological distress. It is hypothesised from these findings that there are negative consequences for relationships due to concealment and repression of an abortion experience which is a significant finding, as this correlates with instances highlighted in the literature that contribute to psychological distress. The findings also revealed the range of emotional and conflicting responses of Irish women and illustrate, that loss and grief are common issues that present in the therapeutic space and is therapeutically considered an important aspect of integrating and healing. The complexity of the decision to terminate a pregnancy for some women is reflected in the findings and the subsequent impact is multi-layered and influenced by many aspects of a woman's life. Given the circumstances that surround abortion in Ireland, this study found strong justification for further research on the psychological impact of abortion on Irish women.

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CHAPTER 1: INTRODUCTION

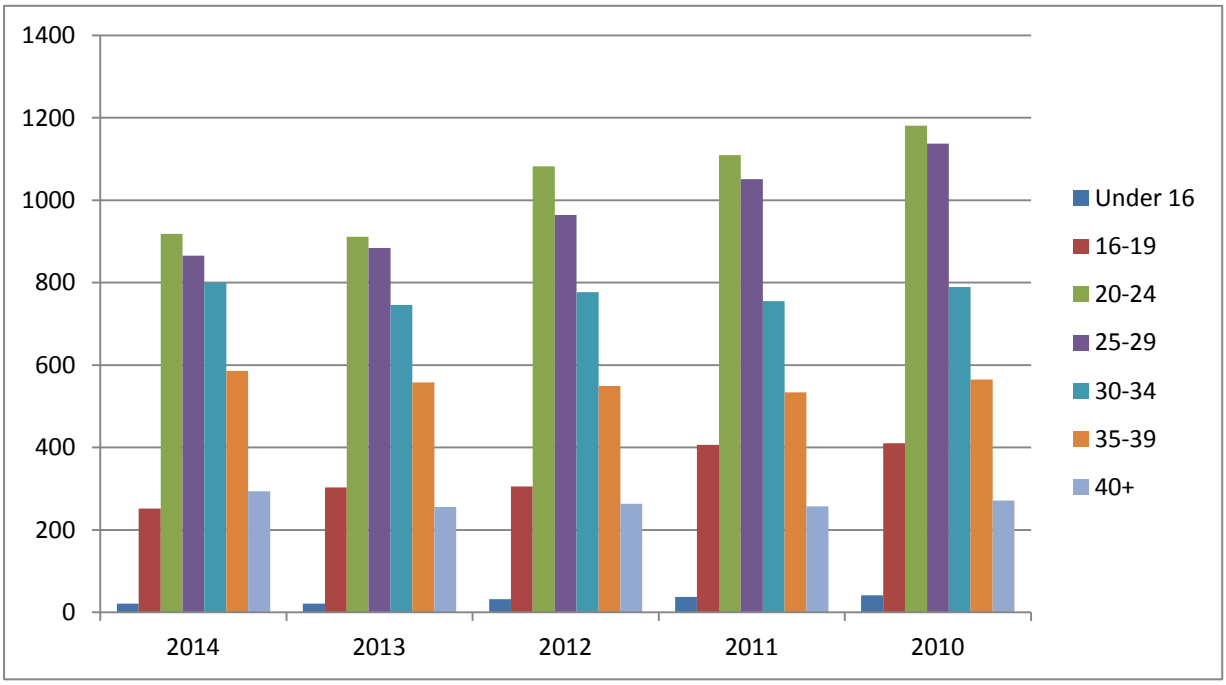
1.1 Background

In an Irish context, the issue of abortion has probably been one of the most divisively debated topics over the last thirty years or more. Successive governments have avoided enacting legislation despite a shift in public opinion, a number of legal rulings and more recently, criticism from the United Nations and European Courts. The passing of the current legislation i.e. Protection of Life During Pregnancy Act, repealed section 58 of the 1861 Act, replacing it with a prison sentence of up to 14 years for anyone unlawfully procuring an abortion in Ireland and permits abortion only where there is a risk to the life of the pregnant woman (Irish Family Planning Association, n.d,). Ireland is company to some fifty other countries where abortion is totally or almost completely prohibited, many of these countries are in the developing world. The debate portrayed in media circles in Ireland tends to emphasise the extremities of the opposing sides and what seems least attended to, is the individual woman at the heart of the situation which is the central focus of this research project.

The statistics and facts that pertain to abortion both internationally and in Ireland are shocking. According to the *Irish Contraception and Crisis Pregnancy Study* (2010), one in every seven pregnancies for Irish women were crisis pregnancies, of which 4% resulted in abortion (McBride, Morgan and McGee, 2010). Between 1980 and 2014, at least 163,514 women travelled from Ireland for safe abortion services abroad, this figure is an underestimation as some women will not register with an Irish address due to issues of confidentiality (Irish Family Planning Association, n.d,). The figure below illustrates the

numbers and age groups of Irish women that travelled to England and Wales to avail of abortion services between 2010 and 2014; the figures for 2015 are not available. Most abortions were performed in the age ranges of 20 - 24 followed by 25 – 29, which is comparable to international statistics. Furthermore this figure does not reflect the numbers of women purchasing abortion pills on line or those that avail of abortion services in other countries. For example in 2009, Irish Customs seized 1,200 pills, no doubt a small percentage of the overall intake.

Figure 1.1 - Numbers of women From the Republic of Ireland Accessing Abortion Services in England and Wales 2010 - 2014



Internationally estimated figures show that between 2010 and 2014, 56,000,000 induced abortion procedures took place worldwide annually, fifty percent of which are unsafe (The Guttmacher Institute, 2016). The majority of unsafe abortions take place in the developing world and incredibly the most recent studies estimate that in 2014 the number of abortion related deaths ranged from 22,500 to 44,000 due to complications from these procedures (The Guttmacher Institute, 2016). These statistics also draw attention to the wider picture that

pertains to abortion, particularly in the developing world. The lack of access to safer contraception, education and information and family planning services all contribute to higher abortion rates. Equally, the prevailing cultural, religious and moral views of the society have a significant influence. Moreover the role and status of women in society is intrinsically linked to the principles that protect or not, her reproductive and sexual rights. Suffice to say that this is an issue of significance for women and society and requires further research.

1.2 Scope and Objectives

In doing preliminary research on this topic, it is immediately apparent that there are a multitude of international studies and research on the psychological impact of abortion on women, but few that specifically relate to Irish women. The aim of this study is to gain a more insightful understanding of the Irish woman's subjective experience, particularly considering the issues of stigma, culture, travel to another country and societal attitudes that may affect her. The Catholic Church for example, has had a significant influence and role across Irish society, particularly regarding its stance on abortion, resulting in an often polarised debate with one side 'pro-life' and the other 'pro-choice'. Fletcher (1995) argues "that the language of choice used in relation to abortion is inappropriate because women's experiences illustrate that terminating a pregnancy is rarely a black-and-white choice between two outcomes, but is often a decision which is affected by many aspects of a woman's life" (as cited in Mahon, Conlon and Dillon, 1998, p. 36). A report from the *Crisis Pregnancy Agency* reviewed the literature on the psychological effects of abortion on women and highlighted the lack of research into this issue for Irish women (Fine-Davis, 2007).

On the face of it crisis pregnancy lies at the root of abortion. In 2012 the Crisis Pregnancy Programme produced a *National Strategy 2012 – 2016* document with specific recommendations for post abortion counselling services (HSE Crisis Pregnancy Programme National Strategy 2012 – 2016). A review of their lengthy submission list highlights a lack of input from the psychotherapy profession. An article from the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP), discussing the lack of regulation in psychotherapy suggests that "there is no real voice for counselling and therapy in Ireland" and questions the silence on the more topical issues such as abortion (Kinneary, 1998, para. 3). It is Kinneary's opinion that the views of psychotherapists are not considered or sought, mainly owing to lack of regulation and inherent self protection attitude that prevails in the profession. The psychotherapy field appears silent on social and political issues, as is apparent in the submissions list on the above mentioned document. Surely an occupation which regularly works with individuals to address their life issues and difficulties, would have a comprehensive view on crisis pregnancy and its implications, but yet the subject of abortion seems relatively unspoken within the profession.

Riddick (1995) suggests that in common with societal Irish norms a therapist may be unreceptive or indeed hostile to the issue of abortion. It is hoped that since this opinion was proffered, public attitudes have changed somewhat, as is evidenced by more recent public opinion polls (Irish Family Planning Association, n.d.). Equally psychotherapists are not impervious to the influence of moral judgements and the value laden nature of the subject. Or is the subject of abortion as Atkinson (2010) proposes "beyond the ordinary language of psychotherapy?" (para. 8). By the same token, does the taboo that surrounds abortion hinder the capacity to stay with this unknown and unfamiliar realm? This study will endeavour to

elicit the reflections and valuable experiences of therapists that have experience in the subject matter. This research topic emerged in response to this dearth of specific research and the recommendations for further exploration into this area. With this in mind the objectives of this research project are to:-

1) Extend knowledge and understanding of the issues that may present for Irish women post abortion and gain insight into the lived experiences of these women.

2) Consider the implications of the societal influence that is specific to Irish women and its impact on their experience.

3) To explore the therapists understanding and perceptions of the presenting issues.

4) To contribute to existing theory by deepening our understanding from a psychotherapeutic perspective.

1.3 Summary

This is a challenging topic to undertake for a research study, being mindful of the often extreme opposing views it evokes. As an issue, it is viewed from religious, moral, ethical, cultural, societal and gender specific perspectives which often has a deeply personal component. It is a subject that is difficult to present objectively without the influence of personal beliefs and values. This was evident throughout all the research and reading into abortion, it is a highly emotive subject and one that requires sensitivity and understanding in its portrayal.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter will present a synopsis on the relevant research and literature. The main focus is to review the existing international research on the impact of the abortion experience on women and any corresponding literature that specifically pertains to Irish women. The review will also explore the specific implications, contexts and themes that apply psychotherapeutically. The research itself is often a topic of debate and controversy and highlights the need to evaluate research with a critical eye.

2.2 Methodological issues in the existing research

The most recent meta-analysis and evaluations have prefaced their findings by highlighting the shortcomings in many of the studies. According to the *American Psychological Association* (APA), methodological flaws are "pervasive in the literature on abortion and mental health" (2008, p. 94) . Similarly the *Academy of Medical Royal Colleges* conducted a systemic review entitled "Induced Abortion and Mental Health", which reviewed the best available evidence with the objective of clarifying the relationship between abortion and mental health outcomes where possible. Their findings present a stark reflection on the reviewed literature concluding that overall the quality of studies reviewed were "poor to fair, with large variation in the study design" (Academy of Medical Royal Colleges, 2011, p. 120). Casey (2008) acknowledges the flaws in the research and proposes that the relationship between abortion and subsequent mental health outcomes is unclear. In such a divisive issue opposing sides can choose to interpret studies and findings to suit their position, for example confusing correlation with causation. More worryingly, it has been suggested that

methodologically unsound research has been used to inform policy making decisions (Charles, Polis, Sridhara and Blum, 2008). One such study concluded that there was an increased risk to mental health following an abortion (Coleman, 2009), which was subject to numerous published criticisms due to methodological flaws (Guttmacher Institute, 2012). Fine-Davis (2007) suggests that even the most thorough research reviewed has limitations due to design factors and external influences that cannot be controlled. Russo (2014) proposes that the reasons for this are complex and are further complicated by the diversity of life circumstances and individual characteristics of women that lead to a crisis pregnancy and subsequent decision to have an abortion. Additionally a woman's emotional response to an abortion is multilayered reflecting the reasons for having an abortion, socioeconomic circumstances, personal characteristics and coping mechanisms. Furthermore studies were taken from countries with differing abortion laws, some, where abortion is available on demand and others where it is available to protect the life of the mother either physically or psychologically, this diversity in legislation may also influence the results. The varying flaws may be thus explained, considering the many variables and factors to be controlled and assessed.

The paucity of research specific to the Irish context is highlighted by a number of sources, alongside of recommendations that it should be undertaken, considering the unique circumstances of an Irish woman's experience (Clare and Tyrrell, 1994; Fine-Davis, 2007; Casey, 2008). This research intends to add material for discussion in a qualitative psychotherapeutic exploration of that experience. Randolph (2009) proposes that new research cannot advance new findings without first ascertaining the validity of existing research, thus this work will advance with a critical eye.

2.3 Abortion and mental health outcomes

Notwithstanding the acknowledged flaws, the available literature on abortion and mental health outcomes is conflicting. This is evidenced by position papers from two professional bodies, namely the APA and the *Royal College of Psychiatrists* (RCPsych) which did not concur on the risk to mental health for those that have undergone an abortion. The former concluded that abortion does not cause significant mental health problems for most women and the latter considers the evidence to be inconclusive (Dykes, Slade and Haywood, 2010). Abortion is not considered a psychiatric issue, but one that touches a number of different spheres of study including legal, moral and ethical and it is therefore not surprising that professional bodies posit diverse viewpoints. More recently a number of literature reviews, evaluations and meta analysis have been conducted on the topic and in general concluded that abortion does not cause mental health problems for the majority of women (Charles et.al, 2008; Major et al., 2009; Academy of Medical Royal Colleges, 2011; Kendall, Bird, Cantwell and Taylor, 2012). These extensive and comprehensive reviews and analysis evaluated previous studies and papers, omitted those that did not conform to strict criteria for inclusion and discussed the merits and shortcomings of those that were included.

In contrast two studies from New Zealand which are often referred to by pro-life organisations, suggested that abortion maybe associated with adverse psychological effects (Fergusson, Horwood and Boden, 2006; Fergusson, Horwood and Ridder, 2008). However these studies are also considered to have "significant shortcomings" due to design flaws (Guttmacher Institute, 2011, p. 3). An article featuring Dr. Julius Fogel, an obstetrician-gynaecologist and a psychiatrist, who at the time had performed approximately 20,000 abortions, stated that in his opinion "There is no question….about the emotional grief and

mourning following an abortion" (McCarthy, 1989, para.1). In his opinion grief manifests in different guises, although a woman will in the main not regret her decision, this does not mean she will not feel a loss. The issue of grief and loss will be discussed in more detail further on in this review. Conversely Fogel has never claimed that abortion is a possible cause of mental illness. Casey (2008) likens an abortion procedure to other gynaecological / reproductive events and suggests that it would be surprising if abortion was not associated with negative psychological outcomes. The contradictory nature of the commentaries, studies and discourses is clearly apparent. Thevathasan (2012) suggests that the "softer" responses that a woman may experience are overlooked by the likes of the APA in their research reviews and proposes that there is a desire to put forward the position that abortion does not in general adversely affect mental health, in order to propagate the pro choice stance (para. 12). Abortion is such a divisive issue with the polar opposites of life and death, creation and destruction at its very centre, which in turn are part of the essential nature of being human. It is a topic on which it is difficult to be truly reflective and reflexive when discussing and even the best studies or researchers can be impacted and influenced by the evocative power of the subject matter.

Notwithstanding these findings, there is little doubt that having an abortion can be a stressful life event, perhaps even more so amongst Irish women who are forced to leave their normal environment to travel abroad. The studies reviewed also conclude that lingering post-abortion feelings of sadness, guilt, regret, remain for a minority of women (Guttmacher Institute, 2011). It is, however, important to note that each woman's experience is valid and unique and that for some women abortion does have a negative psychological impact. The most consistent predictor of subsequent mental health issues is considered to be prior mental

health history *(Academy of Medical Royal Colleges*, 2011). Conversely a predictor does not equate to cause, psychological difficulties are rarely attributable to a single event or factor but are often part of a complex psychological process that includes a myriad of factors. Information from the research also highlights the following instances / reasons that may contribute to psychological difficulties or disorders:-

- Pressurised to have an abortion
- Second trimester abortions
- Stigma around abortion
- low perceived or anticipated social support for the abortion decision
- Interpersonal concerns
- Live in a society where abortion is prohibited or where religious beliefs and or cultural norms have a strong influence
- Abortion due to foetal abnormalities or genetic reasons

(Fine-Davis, 2007; American Psychological Association, 2008; Guttmacher Institute, 2011; Academy of Medical Royal Colleges, 2011)

2.4 Abortion and mental health outcomes from an Irish perspective

The *Psychological Society of Ireland* (1992) highlighted the absence of research into abortion and subsequent outcomes for Irish women and strongly suggested that such research should be undertaken. Some twenty five years later, utilising as many search options as possible, it appears that no such studies have been conducted (as cited in Fine-Davis, 2007). In the

absence of this information, it is presumed that mental health outcomes for Irish women would be comparable to international findings. However some of the factors referred to above that contribute to negative mental health outcomes are particularly pertinent for further reflection in this context. The APA make a significant point in this regard, stating that the "most methodologically strong studies…showed that interpersonal concerns, including feelings of stigma, perceived need for secrecy, exposure to antiabortion picketing, and low perceived or anticipated social support for the abortion decision, negatively affected women's post-abortion psychological experiences" (American Psychological Association, 2008, p. 94).

Similarly in one of the few reviews that refer to the Irish position, Clare and Tyrrell (1994) link the factors of stigma, religious and cultural context, the need for secrecy and travel abroad, as issues for consideration and further research on the potential impact on mental health. Significantly, Clare and Tyrrell (1994) emphasise that it is these factors, not the abortion *per se* that may contribute to psychological distress. These authors wrote in 1994, not long after the Supreme Court ruling on the X case and the issue of abortion was front stage politically, socially and ethically. Over the last decade there has been a significant shift in the attitude towards abortion in Ireland, with a recent Amnesty International Ireland / Red C poll suggesting that "87% of respondents want abortion access expanded, 71% believe abortion should be decriminalised and 38% favoured abortion access as women choose" (Irish Family Planning Association, 2016). Currently, abortion continues to be a 'hot topic', extremely prevalent in contemporary discourse, the research does not exist in Ireland to ascertain how this affects a woman's abortion experience.

2.5 Understanding within a psychotherapeutic framework

2.5.1 Abortion stigma and secrecy

Abortion stigma is of such significance in the literature, that it is defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar, Hessini, & Mitchell, 2009, p. 628). The authors further hypothesise that an abortion contravenes societal gendered constructs of motherhood, the feminine and the archetypal good mother. Boyle (1997) posits that society construes abortion as a rejection of motherhood, resisting what is perceived as the essential nature of women. Psychological theory also places the mother as the central figure in the emotional and cognitive development of children. This theoretical perspective is widespread in psychoanalytic, object relations, attachment theory and more recently in affect regulation theory. The idealisation and sanctity of motherhood has been introjected across society, and is a matter for deeper examination in how abortion is framed. This introject influences how society, particularly women, view and respond to abortion. Another ideology to be considered within abortion stigma is that of "pronatalism", that is "the notion that a person's social worth is inherently linked to her or his ability to procreate and raise children" (Parry, as cited in Mollen, 2014, p. 163). In addition to violating the ideals of motherhood, a woman that has an abortion also contravenes the principles of the pronatalist ideology. Allanson (2007) for example, proposes from her research, that a society that prioritises motherhood would be "uniquely confronting" for women considering an abortion (p. 57)

Research highlights that two in three women, that have had abortions, expect to experience stigma, while 58% felt they had to conceal their experience from family and friends (Shellenberg, 2010). Alongside the abortion experience, women may also envision that they

would be labelled as irresponsible, promiscuous and selfish by becoming pregnant in the first place and further stigmatised for rejecting motherhood. Kimport, Foster and Weitz (2011) found that such negative appraisals can have "long-term emotional consequences" for some women through the internalisation of stigma (p. 108). Shame can be a powerful and painful emotion, particularly for all ready fragile self. In the case of an abortion experience which may already be attached to shame, the fear of exposure can escalate the shame feeling and negatively affect self worth. Correspondingly Cockrill and Nack (2013) suggest that abortion stigma can have negative consequences on self worth, self image and result in isolation from peers and social support. It can also be theorised that these negative feelings, which cannot be released, are retained in the body's nervous system and musculature and may be experienced somatically (Levine, 1997). The research is lacking into the effect of abortion stigma on the embodied self.

Cockrill and Nack (2013) further purported that this self stigma was more prevalent amongst women that came from communities where there was a negative attitude to abortion. Correspondingly Shellenberg et al., (2011) examined the existence and depth of abortion stigma in a study across five countries and found that it was similarly perceived, but more evident in countries with more restrictive abortion laws. The notion that abortion is morally wrong is reinforced in Ireland, where it is still preserved in the law as a criminal act and if found guilty a woman is liable to a maximum sanction of 14 years imprisonment. The research has not yet been conducted to determine if this adversely impacts the Irish woman's abortion experience. Furthermore individuals react to perceived or felt stigma differently, and depending on for example, how central it is to their self concept and sense of worth.

Equally levels of self efficacy, resilience, coping mechanisms and other personal attributes may also mediate its effect by internally managing the stigma.

The fear of moral condemnation and social disapproval also forces a woman to keep her abortion a secret, not trusting others to support or validate her experience. Enforced secrecy therefore, is a direct response to stigma. Another study that examined the relationship between concealment and psychological distress concluded that, there may be high intra-psychic costs associated with non disclosure due to abortion stigma (Major and Gramzow, 1999). They further hypothesised that secrecy and purposeful concealment can cause disruption in cognitive processes and result in intrusive thoughts about the abortion, leading to increased psychological distress. Estés (2008) further proposes that repressing secrets that are attached to shame and guilt have deeper repercussions on a woman's unconscious, deadening parts of the psyche that manage and respond to feelings and emotional events. Fletcher (1995) in an article entitled *Silences: Irish Women and Abortion* explores the social, legal and political environment that Irish women are exposed to. Fletcher (1995) hypothesis's that there is a relationship between women's silence and the public debate on abortion which further inhibits them sharing their experiences. Nevertheless there are also positive aspects to concealment of an abortion, such as retaining social relationships, status and avoidance of negative feedback. Interestingly the same study also found that disclosure did not impact on the frequency of intrusive thoughts, but it was a factor in moderating the impact of intrusive thoughts on psychological distress (Major and Gramzow, 1999).

2.5.2 The benefits of emotional disclosure

A recurring theme across the literature was the need for a woman to have her experience validated, not censored by others, being able to share a stressful life event in a supportive environment is important in any context. Major and Gramzow (1999) emphasise the benefits of emotional disclosure, particularly for women that were experiencing psychological distress as a result of their abortion. An abortion should be a private matter for any woman, but their 'private' experience is ensnared within the publically polarised discourse that has produced a socially constructed stigma and resulting secrecy that can have far reaching consequences for the woman. Discourses on abortion tend to transcend the range of what is considered normal and into the realm of taboo, which in turn polarises, stigmatises and engenders high levels of anxiety and emotions. Even its linguistic origins reflect as much, the original term in German text is *Ab-ort*, literally translates as "a place to be avoided" (Zoja, 1997, p. 6). Psychotherapy if required should create the space for a woman to manage and integrate her experience. It also provides the opportunity to explore any underlying dynamics, unconscious processes and conflicting feelings that are contributing to psychological distress, which will be examined in more detail below (Abelin-Sas, 1992, Loader, 2010).

2.5.3 Unconscious processes

As referred to earlier there is scant psychotherapeutic research or studies that specifically discuss abortion, with the exception of post abortion counselling handbooks. A number of authors note this in their writings and surmise that the complexity and multifaceted layers of this contentious topic contribute to the lack of discussions (Remeikis, 2001; Atkinson, 2010). Nonetheless there are some psychoanalytical theoretical concepts worth mentioning in this review. Both Loader (1995) and Zoja (1997) posit similar theories on the unconscious

motivations and meanings behind an unplanned pregnancy and subsequent abortion which are usually related to unconscious conflicts in childhood that have not been resolved. A woman may unconsciously wish for proof of fertility, proof that she can meet the cultural expectations of the feminine, particularly if she has not been guided by her own mother to appreciate or understand her own bodily functions (Zoja, 1997). Women learn much from their mothers both consciously and unconsciously and their identification with a pregnancy is influenced by their own experience of mothering. The mother becomes part of what Bowlby referred to as an" internal working model" that could be described, as a mental map for future reference, which both influences and shapes behaviour and expectations and engraves patterns of emotional experience in the psyche outside of conscious awareness (as cited in Wallin, 2007, p. 27).

Pines (1993), vociferously contends that pregnancy is a developmental task in the "separation-individuation" by the daughter from the mother (p. 13). Pregnancy can be viewed as the desire to become an adult, or in contrast the desire to regress to a childlike state (Loader, 1995; Zoja, 1997). These desires and fantasies unconsciously shape a woman's response to an unplanned pregnancy. Other fantasies are connected with pregnancy, such as the act of creation, Zoja (1997) theorises that an unplanned pregnancy may be an expression of power that masks low feelings of self worth. Women have the power to produce the 'heir' is a notion that still abounds in society today. Contrastingly Abelin-Sas (1992) theorises from clinical experience, on the theme of destruction, the fantasy or primitive desire to kill the foetus. Chodorow (2003) further speculates on the unconscious feelings about motherhood, ambivalence resulting from internal conflicts and fears about mothering that cannot be acknowledged or expressed may result in an abortion. An examination of the

psychoanalytic theories on abortion, proposes that many were devised as a result of specific clinical case studies of clients already in therapy and other confounding variables would not have been controlled (Major et.al, 2009).

Similar to the cultural construct of motherhood, Abelin-Sas (1992) theorises that the ego holds the historical myths of the archetypal mother passed down through the generations. A person does not develop in a vacuum; each relational being is interwoven with the wider collective. Formation of self is a dynamic process influenced by connections and interactions both internally and across the collective and that self becomes multilayered through experience. If the facilitating environment has not provided a good enough experience that enables the capacity for self regulation, self care and self worth, this may lead to acts of self destruction, relationship issues and difficulty managing emotions. Surely these are salient features that should be considered in the discourse on unplanned pregnancy and abortion. The research and writings do not, on the face of it, offer much in the way of discussion or acknowledgment in this regard. The considerations outlined here, do not question or cast doubt on the decision to have an abortion but should be seen as additional aspects for consideration from a psychotherapeutic viewpoint.

2.5.4 Emotional responses to abortion

Notwithstanding the numerous findings in the research, there is more to the termination of pregnancy than statistics and data. Both the decision to have an abortion and the abortion experience itself, are complex matters for women. Each woman's experience is unique, life experience, history, environment, values, morals and role in society are all factors that affect a woman's decision and subsequent responses. Despite what societal, cultural or theoretical

influences prevail, a woman attributes her own meaning to abortion. Abortion is a stressful life event that is beyond the normal range of experience and may evoke profound emotions (Davies, 1991). Women experience a range of emotions post abortion including satisfaction, relief, sadness, anger, ambivalence, guilt and shame, some of which may linger for a number of women. These emotional responses and any subsequent negative psychological effects must also be considered in the context of the woman's reasons for viewing the pregnancy as unwanted and her personal circumstances at the time (Russo, 2014).

It has been theorised that an abortion can lead to "postabortion syndrome" (Major et al, 2009, p. 866) however, this is based on the premise that abortion is a traumatic experience and the majority of the research would contradict this assumption. Furthermore postabortion syndrome is not recognised as an identifiable mental health condition by the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition), (American Psychiatric Association, 2013). Needle and Walker (2008) devised a guide for therapists working directly in post abortion counselling. The authors caution therapists not to presume that an abortion will necessarily cause a negative emotional response or consequences, as cultivating positive coping beliefs has shown to be effective in mediating long term negative outcomes.

Three studies examined the longer term effects of abortion on women and reported similar findings (Adler, 1975: Goodwin and Ogden, 2007, Dykes, Slade and Haywood, 2011). Women reported mental distress and negative emotional responses post abortion due to inadequate support, experience of social disapproval and judgement, and experienced internal conflicts and concerns about the abortion. For some of the women these feelings were persistent or repeated over long periods of time. Dykes et al. (2011) research demonstrated

that reaching menopause age was a vulnerable time for women that have had an abortion, if for example their wish for children had not been fulfilled. Their research also indicated that some women experience difficulties adjusting in the longer term. The first-hand accounts written by women highlight the diversity and duration of emotional responses that are associated with the experience (Davies, 1997). The research though, seems limited concerning the possible longer term impact of abortion.

2.5.5 Loss and grief

The themes of loss and grief are common throughout much of the reviewed material. Brien and Fairbairn (1996) suggest that sadness is the most prevalent response amongst women after an abortion. Abelin-Sas goes further and posits that sadness is "inherently present" in the experience. Additionally it is highlighted as one of the emotions that may linger for some women and contribute to psychological distress (American Psychological Association, 2008; Academy of Medical Royal Colleges, 2011). Sadness and loss are more complex issues within this context. A woman may find it difficult to acknowledge that loss is a normal emotional response. Equally they may believe they do not have a right to feel sadness or grieve, as abortion can be considered a socially negated loss that is not condoned by society (Worden, 2009). Also women may be grieving the symbolic loss of motherhood or a fantasy of what might have been if the circumstances were different (Davies, 1997; Needle and Walker, 2008). Moreover loss and sadness are painful emotions and a natural coping / defence mechanism is to suppress these feelings, as if the experience never occurred. The feelings of ambivalence that are associated with an abortion experience can be partially attributed to this suppression. The presence of ambivalent feelings is often a trigger for the utilisation of defence mechanisms (Jacobs, 2010). Additionally ambivalence arises when a

woman is certain of her decision, but surprised at the subsequent depth of feeling it generates (Brien and Fairbairn, 1996; Loader, 2010). Freud's explanation of the dynamics of melancholia as prolonged mourning has relevance here (Freud, 1917). The woman's relationship with the foetus could be considered ambivalent, as she may view her pregnancy as unwanted but equally have an emotional connection to the foetus and or future hopes of motherhood. This unresolved ambivalence may be turned inwards and result in self recrimination and self sabotage. Repeat abortion experiences could be considered in the context of this self sabotage. Freud theorised further that the unresolved ambivalence in mourning "belongs by its nature to the repressed" (1917, p. 257). The unconscious feelings may be triggered at a later stage and manifest in the deferred affect of disenfranchised grief or in other symptomatic affect. The elements of disenfranchised grief are particularly pertinent in the discussion of grief in the abortion experience. It is a loss that is not publically acknowledged, nor socially supported, there are difficult circumstances in the death and the relationship is not always recognised (Doka, 1989). For the therapist working with a woman where abortion is an issue, there are many elements and nuances to consider in the work and how these may present for a client.

Research suggests that post-abortion counselling is an effective intervention and may help mitigate against subsequent emotional distress or negative psychological effects (Faure and Loxton, 2003; Worden, 2009). Whilst the majority of women may not require such counselling, additionally women that may benefit do not seek it (Fine-Davis, 2007). The secrecy and stigma that surround abortion in Ireland will more than likely contribute to women not getting the help they need.

2.7 Conclusion

Casey (2008) highlights the lack of evaluations on psychological interventions for women post-abortion and this research will, contribute additional information for practitioners when working in the psychotherapeutic relationship. In conclusion one of the most important factors for women in adjusting to and dealing with their abortion experience is to have it validated and acknowledged by others in a supportive manner (Davies, 1991). This holds true for the psychotherapeutic profession also, it is hoped that a therapist will be able to set aside their moral stance, on a topic that engenders so much anxiety and controversy and meet the woman in a supportive and non judgemental capacity.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter will outline the methods used to carry out this research. It will explain the reason for taking a qualitative approach that includes the use of semi structured interview and qualitative thematic analysis to examine the data. This section will also introduce the participants; the procedures adopted and consider the ethical implications of this study.

The researcher is aware that this topic is of a highly sensitive nature, not just for an individual personally but for society in general. Siber and Stanley (1988) describe "socially sensitive research as research….in which there are potential social consequences or implications, either directly for the participants or for the class of individuals represented in the research" (as cited in Birchard, 2006, p. 156). This research is not being carried out to provide data for interpretation by either side of the debate, but to extend knowledge and understanding of the issues that may present for Irish women and deepen understanding from a psychotherapeutic perspective.

3.2 Research Method

McLeod (2003) stated that "research is a systematic process of critical inquiry leading to valid propositions and conclusions that are communicated to others" (p. 26). He elaborated further in discussing counselling and psychotherapy research, discerning that in the wider counselling research there are two particular forms. One that informs therapeutic approaches to specific problems and another that informs the therapist on how a problem may be experienced by an individual. This research will attempt to provide insight into the Irish

woman's experience of abortion providing a deeper understanding of the nature and meaning of their experience.

A qualitative method was chosen for this research, as it was felt that this would provide the most accurate means of understanding the topic and give due consideration to the therapeutic dynamics in operation. Dallos and Vetere (2005) suggest that the qualitative method allows the researcher to explore and understand the meaning of a person's experience and also gives a voice to the participants with their descriptions of a given phenomenon. The qualitative approach, according to Landridge (2004) can "produce unexpected insights about human nature through an open-ended approach" (p. 15). Crucially this allows for a flexible approach through which additional topics may emerge that provide further insight. This form of research is not rigid and aims to capture the essence of the experience through qualitative data collection methods and is considered most suitable for this piece of research.

3.3 Research sample

All participants are qualified accredited psychotherapists with the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP). Participants were selected on a range of criteria including length of time working as a psychotherapist and experience in the subject matter. The research population consisted of five accredited psychotherapists four female and one male. Of the five participants, four are IAHIP accredited supervisors with over 15 years experience each. All participants are self employed in private psychotherapy practice.

3.4 Recruitment

The recruitment process commenced, by initiating contact with a number of psychotherapists known to the researcher. This resulted in a purposive sampling technique known as "snowballing" where the first interviewee recommended two other willing participants (Hanley, Jordan and Wilk, 2014, p. 98). One of these participants was a male therapist which was an important factor for the researcher to get an input from a male perspective, considering that the subject matter is perceived as an issue that pertains to women in the main. A further therapist expressed an interest in participating having viewed a poster presentation on the research project and was subsequently contacted and asked to participate. The final therapist was directly emailed and requested to participate due to her knowledge and experience of teaching and working with issues that pertain to women.

3.5 Data Collection Method and Analysis

3.5.1 Data Collection

Semi structured interviews were used to conduct this research, as the main purpose of such interviews is to "describe and understand the central themes the person experiences", they are considered the most effective to elicit the relevant information (Mcleod, 2008, p. 75). As referred to earlier, the abortion experience for women is complex and multifaceted. This form of interviewing also allows a deeper exploration of issues that may be too complex to probe through quantitative methods (Banister, Burman, Parker, Taylor and Tindall, 2006). McLeod (2008) also states that this form of qualitative research interview can be a positive experience for the researcher, as was the case for this researcher, by gaining access to rich subject matter that the therapists' accounts provided. One to one informal interviews also

provide the space for richer exploration of experiences through prompting, noting of body language, through which the "sense of encounter as a mutual interview is emphasised" (McLeod, 2003, p.76). The questions for the interviews were compiled by identifying the main themes in the literature review so as to maintain relevance and connectivity with the aims of this research, but also remained open for new concepts to emerge. A digital Dictaphone was used to record each interview. Each participant was asked to give consent to be recorded and for the material to be used in the research project. The interviews were subsequently uploaded onto a laptop and transcribed within a short timeframe, then saved and password protected.

3.5.2 Analysis

Thematic analysis was used as the method for identifying, analysing and compiling the themes from the obtained data set. A thematic analysis is a qualitative approach to data analysis that avoids imposing meaning on the data collected and emphasises meaning for the participants (Joffe, 2012). In this approach the researcher is active in the process by enabling the researcher to collate the data and interpret the various aspects of the research topic. In this active context, the researcher is also cognisant of the influence of personal beliefs on the data set as researchers can consciously and unconsciously influence how a story unfolds (Bager-Charleson, 2014). Atkinson for example carried out research in the field of abortion therapy and gives a very honest account of how embedded personal beliefs and values impacted the research, she evaluated further that "even the most empirically based positivist approach was open to bias and interpretation" (as cited in Bager-Charleson, 2014, p. 91). Throughout the course of conducting this research, this topic was and continues to be, extensively covered and discussed across many media platforms. With this in mind the

concept of reflexivity, as involving openness to opposing viewpoints and assumptions, without losing sight of the subjective stance is ever present.

The transcripts were then read and re-read to familiarise the researcher with the data with an initial analysis carried out for identification of common trends and areas of prioritisation for inclusion. The data was then organised in a systematic way by coding large amounts of data into meaningful groups, to enable answering of the research question in a balanced manner (Joffe, 2012). At this point patterns and themes emerged from the coded data and these were identified and captured. According to Braun and Clarke (2006) a theme encapsulates important information in relation to the research question; the themes were edited and refined, under the headings of themes and sub themes. Information from additional comments and suggestions through open questioning techniques was also considered and tested for merit of inclusion against current thinking and theory. Comparable tables and conceptual diagrams were used.

3.6 Ethical Considerations

For the participants a number of considerations were taken into account. The researcher contacted the participants and explained the nature of the research project and the process that it would entail. The interviewees were subsequently emailed information sheets and the questions that would be asked (Appendix A & B), to allow the participant's time to reflect on the material prior to interview. The researcher arranged times, dates and suitable venues to conduct the interviews. All interviews were conducted in private, considering the sensitive nature of the material that would be discussed. The purpose of the research was again

explained prior to commencement of the interviews and each participant completed a consent form (Appendix C). Each participant was informed that they were being recorded according to ethical guidelines, and that they had a right to withdraw from the study at anytime. They were also informed that their identity would not be disclosed and pseudonyms were used in all documentation. They were assured that as much as possible would be done to preserve their anonymity and confidentiality. All data collected and field notes are stored by the researcher in a secure location.

3.7 Limitations

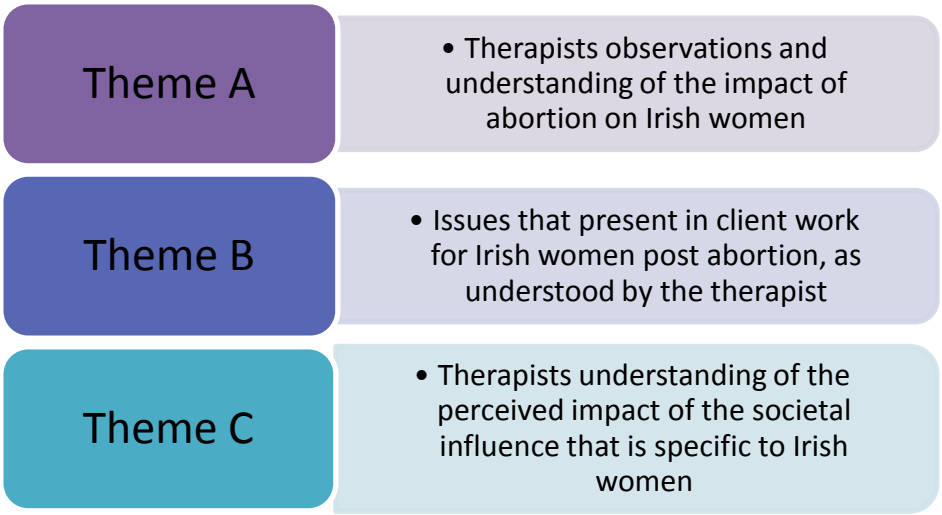
There are a number of limitations to be considered in this research project. Qualitative analysis does not reflect generality and as such generalisations should not be drawn from this data. The attitudes to abortion in Ireland appear to be shifting and it cannot be assumed that women who choose to terminate their pregnancies today will experience the same reactions. As the people referred to in the results were already attending therapy, variables such as pre existing factors that would contribute to their abortion experiences were not controlled for. Finally critics of qualitative methods suggest that it is prone to the personal bias of the researcher. Considering the politically sensitive nature of the topic, equally the potential personal bias among the participants, is also something that cannot be controlled or accounted for.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter will outline the results of interviews that were conducted with the five therapists in relation to their experience of working with Irish women that have previously had an abortion. The patterns and themes that emerged from the coded data were identified and captured. Further analysis of second and third order coding was carried out, and three main themes were identified (Figure 4.1). The findings are explored in this chapter and substantiated by quotations from the participants. The participants have been given pseudonyms to protect their identities. Examples of their client work will be used throughout to demonstrate the themes. It is significant to note in these findings, that all the client examples had undergone an abortion some considerable time prior to it emerging in therapy. There are two exceptions to this which are signposted in the themes.

Figure 4.1 Identified Themes



4.2 Therapists observations and understanding of the impact of abortion on Irish women

Analysis of the data revealed how the participants viewed the impact of the abortion experience on the women they worked with. The quantity of experience in the subject matter varied across the participants, which was somewhat reflected in the information gleaned. Equally though, similar themes emerged across all the interviews in relation to the impact of abortion. All of the participants identified psychological effects in varying degrees, which they perceived as directly related to the abortion experience. Three of the participant's also highlighted psychosomatic manifestations, which they believed, significantly affected their clients. In general abortion was not normally the presenting issue, except in two cases, and usually emerged later into the work, where its impact then became the focus.

It was interesting to note each therapist's interpretation of the experience of abortion and how this is reflected in their view of the impact. Val described it as a trauma, similar to that of a miscarriage and adoption. Val elaborated further on this specific area of client work, emphatically describing abortion as a traumatic experience within an embodied self for these women.

> *"I think there is a connection between women who have experienced miscarriages, stillbirth and abortion – and..em…I think that's an important connection to make, because the body has gone through a trauma in each one of those situations, the woman's feminine psyche has gone through a trauma connected to the spirit and the heart…they are not separate issues."*

Frank depicted abortion as a "*traumatic moment in their lives…that is etched on their psyche*" and described the impact that he has seen in his work. Throughout the interview this participant emphasised the theme of loss, more specifically unresolved or unacknowledged loss, as the underlying issue the subsequent impact this has on the women he has worked with.

> *"I have had many clients that have had severe issues around abortion, which are not usually the presenting issue….there was only one case where the abortion was present on the first day, it's usually after digging over a few sessions before you discover this great loss in their lives"*

Megan in contrast described the journey abroad and the surgical procedure itself, as a traumatic experience, but did not agree that abortion would necessarily result in negative psychological affects. However she later referred to the adverse effect of both secrecy and stigma, which will be analysed later in this text. Clare also differed and did not wish to give an abortion experience a specific label, stating that "*whatever way you frame it there is always a reaction"* and elaborated further from her client work.

> "*I have worked with maybe fifteen women who have had abortions and there are various degrees of woundedness or stuff they carry from that…*

Trauma is defined as an experience that a person perceives as a life threatening or overpowering event and whether the clients referred to would agree with this definition, or categorise their experience as such, is not known or validated in this analysis (Levine, 2008). The question could also be posed that if abortion is essentially viewed as a trauma with corresponding trauma symptoms by a therapist or anyone for that matter, would that influence their perception of its possible impact.

Frank noted the varying degrees of impact and attributed this to the different personal characteristics and coping mechanisms of clients, suggesting that *"some people are very good at burying it very deep…and eh...pretending like it never happened, but the dreams, hopes and wishes always come back up for them".* This coping / defence mechanism of detachment or denial was common across the five interviews and is evident in these vignettes. There was a consensus view that an abortion experience was often buried and put out of conscious thought, which resulted in emotional distress and difficulties in coping. Maria attributed this to a lack of connection for her clients, in the sense that a past experience was not cognitively or emotionally linked to their current difficulties.

Clare added:

> *"by the time they get here it has begun to cause them difficulties in their life either physically or emotionally, up to that they have been compartmentalising it….and distancing…it was a head thing rather than a feeling thing".*

Similarly Val portrayed a similar process:

> *"Separation of the head from the heart, I think that manifests in em…well linear thinking as opposed to em (long pause)……at the same time something else is going on"*

Furthermore, all of the narratives either described or alluded to psychosomatic effects in their clients, again similar to perceived psychological impact this also differed in severity of affect. Frank made reference to a client that had suffered from "*chest complaints and abdominal distress*" and directly related these physical symptoms as a psychosomatic residue of their abortion experience. Three of the participants referred to how an abortion can affect a woman's sexuality and how they perceive themselves as a woman. Val has experience of

working with both Irish women and has also worked abroad with women that were affected by abortion. She recounts from her experience

> *"they actually don't want the child and that carries with it all kinds of problems in terms of how they feel about their body and how they feel about themselves as a female and it may have some deep issues around sexual identity…these things need to be explored"*

Clare added:

> "*it had to do with image of themselves, their sexuality how they felt about themselves as women.*.",

and elaborated further with a specific example:

> "*there was some level of disgust with their bodies having let them down, one spoke clearly about her body letting her down, getting pregnant in the first place…"*

Finally, another factor that was common across the interviews was the potential impact of abortion on relationships either existing or potential. Relationship emerged across different aspects of women's lives in the interviews, including the relationship with the father of the baby, with siblings, parents and friends. It also arose in terms of secrecy and if, it would indeed be possible to form a new relationship and reveal their experience. Accordingly trust also materialised as a theme, it being central to relationship. Megan told of one client's particular experience in which she had chosen not to tell her husband she had an abortion:

> "*it was her husband's child, the torment for her…the guilt, it was the presenting problem in a mix of things but it came out very quickly*"

Clare also gave a clinical example:

"One woman...who's mother was dying of cancer. It had caused a rift between them, the secret… she knew the rift was on her side because she had kept the secret, her mother may or may not have known, she struggled so very much…she wanted to clear the energy between her and her mother"

This theme has illustrated the impact of abortion from the perspective of the therapists, with reference to their clinical work. The data indicates that the impact varies in severity and nature and affects different aspects of a woman's life including psychological, intra-psychic, psychosomatic and relational.

4.3 Issues that present in client work for Irish women post abortion, as understood by the therapist

This section will utilise the clinical examples to demonstrate this theme, as they provide vivid and pertinent material for consideration and discussion. Analysis of the data revealed that there were common emotional responses expressed by women that emerged in their work, and the additional impressions formed by the therapists regarding these emotions. At times throughout the interviews, these were discussed in general terms, with corresponding examples referenced from client material. Clare noted the commonality of responses from the work in her narrative:

"there are problems common to all such as guilt, shame….. regret in some cases, fear of being found out, fear they may not be able to have a baby, fear they are being punished for one they got rid of…"

The emotional responses noted including fear, shame, guilt, self reproach, sadness and isolation were noted by the participants as prevalent in their work. Val and Maria offered

similar evocative descriptions of the depth of feelings expressed "*deep well of sadness*" and "*deep wounds of regret, sadness, guilt*" respectively. Three of the interviewees explicitly commented on the mixed emotions and confusion about feelings, in some of the narratives this was attributed to the complexity of the issue for women. Frank articulated:

> "*The emotions are strong because there is so much involved, you know…so many dreams, hopes and desires. You imagine how your life with the baby will be, how your life will change etc….em….then on the other side of that they imagined some sort of…..(pause).. reverence over the death of the baby or foetus, but it never happens"*

Nowhere was this complexity and ambiguity more evident than with the concept of regret. Maria described one client's struggle with the decision, being caught between her parents that wanted her to continue her pregnancy and her partner who did not want it to continue and the subsequent difficulties that arose for her.

> *"she really didn't deicide for herself what she wanted to do because she was torn between both sides without giving herself a chance..em she ended up having abortion and while rationally and logically she felt it was the right thing, she for a few years later..she still hadn't gone past it and there was an impact on the relationship..em…and she had huge regrets without thinking she wished she hadn't done it, she was very confused and I think part of her confusion…because she never gave herself a chance to know what she wanted…and she was torn and upset"*

She added that the main issue in the work with this client was the extent to which she did not really know herself, which was what she struggled with in therapy. This example also highlights the conflict in the decision making process, particularly when it is influenced by others. Clare also discussed particular client experiences:

"one talked a lot about confusion, she questioned was it the right thing at the right time, would I have changed my mind, this woman found it difficult to find a resting place for herself in it……..only two I know said it was right decision for me at that time, there was some regret but right decision"

Frank referred to one particular client:

"It took my client almost two years to tell me she had an abortion when she was younger….it made so much sense then…..you know…her relationship to her son, her over protectiveness…the constant anxiety…

In contrast two of the participants referred to clients that mentioned having had an abortion which did not seem to have any adverse effects. Megan recounted one woman's story:

"another woman who felt no guilt, she was just so relieved she could do this, em I think it just came in as part of her story but wasn't a big deal, but she thought it was shocking that she had to go to England…"

Clare added:

"I don't think I've met anyone who really regretted doing it…they may feel sad, they have gone through a grieving process, they may feel guilty whatever…they went through feelings, which is natural but they feel they made the right decision…"

This data appears to illustrate the diversity of responses and the variety of factors that influence a woman's response. The conflicting sense of regret mixed with the certainty of having made the right decision materialised in four of the interviews. In contrast Val did not

make any reference to regret, ambiguity or confusion. Her fundamental belief that abortion is a trauma to the body and the psyche was the dominant theme of the interview, which was in her experience how it presents in the therapeutic space.

The analysis indicates that loss and grief was a common issue that arose in the work with their clients, for all of the therapists. It was considered an important process to work through as part of the healing of unresolved material around the abortion experience. For Frank the issue of "*grief and loss*" are prevalent and he specifically referred to disenfranchised grief as particularly applicable to the subject matter. Similarly Clare's example portrays the quintessence of socially negated loss with a specific example:

> "*it goes underground, that's what affects people very badly*, she repeated her client's words "***I can't be openly sad****..…she described at being at a funeral of an aunt where she could actually cry*"

Four of the participants mentioned using a type of ritual intervention with their clients, which in their opinions formed an integral part of the healing process. All of the participants stressed that, this would only be considered when appropriate and with the client's full agreement and readiness. Clare gave an example:

> *"Working on letting go of shame, judgement, forgiveness (pause)…I remember performing a ceremony with a woman, a ritual, naming ceremony, gratitude, she came in willing to work with it……couldn't smack of anything religious, I put different words on it…various degrees of ritual, naming, honouring and letting go"*

Val discussed how she works with women and elaborated further on her understanding of it as an affective process:

"I've worked with women..we have the ritual ya know…loss, with a letter, made something beautiful to represent the child. See there's a parallel process that happens with the abortion, the child's aborted say at two and a half months, on one level…say at the psychic level the pregnancy continues in the woman, the woman is actually aware when that baby will be born and that's a psychic level of em…….but this is very real and its very real for women"

Maria described a similar sentiment of remembering but more as a cognitive process:

"It wasn't that she couldn't have kids…it was the minute she wasn't pregnant, it was like it came up as a punishment and she was very aware of every year what age the child would have been, stayed with her….certainly a sense of loss because she was grieving that child"

To conclude the presentation of this theme, all the participants stressed how important it was to meet the client in a non judgemental space and to validate their experience. It was also noted that being able to talk openly about their experience in a supportive environment, appeared to alleviate some of their distress. Frank made an interesting observation and wondered if his gender was an influencing factor: "*I wonder does it make it easier or harder for them to open up to a man*". He also highlighted the significance of opening up for these women and the positive experience for him as a therapist:

"Just one thing, despite the impact, the weight of the story, the troubles it has produced. I have found that working with a client with these issues is highly rewarding, it's like when they open up, the em..release from the mental torment is massive, it brings positive effects on every part of their lives"

4.4 Therapists understanding of the perceived impact of the societal influence that is specific to Irish women

Although elements of this theme were a specific question for the interviewees, significantly, it surfaced in all of the interviews as a consideration prior to it being raised by the researcher and interestingly evoked an emotive response in most of the participants. This is not surprising considering the current prevalence of abortion as a topic across many media platforms in Ireland. The main aspects within this theme that emerged were the effect of secrecy and stigma, which is embedded within the cultural and societal influences of the Irish context. Similar to the previous themes, this was discussed in general terms with specific references to client material, which portray the depth of the affect. Megan presented a relevant example that occurred recently in her practice of a client that had just returned from Britain having undergone an abortion procedure. She clearly describes the client's emotional turmoil:

"the absolute feeling was fear of not being able to tell anyone, absolute sheer terror….. she had a lonely road, she didn't want to come back…you know, in absolute panic, her fear, she didn't want to tell her mother which she had a great relationship, I wondered about that (pause)…so she went over on her own"

Megan pointed out that this recent case highlighted the ongoing and difficult circumstances in Ireland, that force a woman to travel abroad and the subsequent fear of not being able to tell anyone of their experience. For her client, the only space she felt was available to her to reveal her secret was with the therapist. Frank elaborated further "*the stigma and the secrecy that surrounds abortion has made it some sort of dirty activity that is then disenfranchised*". In focusing on the issue of stigma, three of the participants drew parallels to how historically pregnant women in Ireland have been mistreated. Examples were cited such as:

Clare noted:

> "*we are not even one generation away from the Magdalene laundries, most women were shunned*" then elaborated further from her client experience, highlighting the stigma felt by a woman by getting pregnant:
>
> *"the majority of them felt some sort of stigma, one woman was really angry…her friend was sleeping with lots of men, she did it twice and she was caught…"* and "*I'm also thinking of two or three women I worked with, they didn't want to be labelled, they felt if they did disclose they had an abortion at sixteen or seventeen, they would be labelled as a slut"*

Similarly Megan referred to:

> "*the women in the past who were packed off to have babies and come back all smiles*", she further described one woman's experience in England and the affect it had on her:
>
> "*One woman had to walk through placards in England, awful thing to walk through that, she found that invasion and judgement horrible, people go through a lot…."*

Val elaborated further:

"the stigma is there for women that miscarry, the stigma of stillbirth, adoption, abortion,,,, so let's stop making abortion different…it is all the same thing, it is really about the woman's sense of connection to their own body and other women".

Further discussion in the interview with Val elicited the viewpoint that the notion of stigma is somewhat irrelevant, because an abortion experience has a direct harmful effect on a woman:

"whether you have Catholic Church or not, a woman would still feel she had done something wrong when she aborted life….because she has done something to her body, ……..what it was created for"

Analysis of all the narratives in general suggest, that the enforced secrecy which Irish women maintain around their abortion experiences contributes to their distress and hinders resolution of any unresolved feelings. All of the participants illustrated examples from their client work. Frank's example below also shows the mechanisms of denial and detachment as coping strategies. Denial in the context of abortion occurs on two levels, firstly it provides relief from painful feelings and secondly it protects against perceived stigma.

"One client coped by burying it, she was not able to talk with her partner about it…she just existed by throwing herself into her work and other kind of distractions to survive… you know, the relief when she started to talk about it was palpable"

Clare suggested that abortion was still "*so covert…still so hard to talk about in Ireland*", she described one woman she worked with:

"One woman said I brought it on myself, I don't have the right to be upset, because you did it….look at the gambit of emotional baggage, anger, resentment (pause)…shame, hurt, sadness, grief…she had to carry with her.."

In contrast Maria described it as "*a self imposed secrecy, ya know…I couldn't bear for anyone to know…that sense".* The secrecy of an abortion experience may indeed be self imposed, but there are contributing factors to the fundamental nature of abortion stigma and its resulting secrecy. Maria also illustrated a very different clinical experience of a client she was working with, who had an abortion whilst in therapy and did not tell her. The subject arose at a later stage only because the client's parents found out, in the therapists opinion, the abortion did not appear to have an impact on her client. Maria wondered about the non disclosure twice in the interview:

> *"that client that never said a word, I had no idea, she was coming in every week to me…I really do, one would assume that you would use the facility, but maybe that's telling…she did it all in such a hurry, that maybe, that to talk to me, that might have worried her, it might have slowed her process down"*

It would seem unusual for a client to not want to use the therapy space to discuss her abortion decision and the reasons are unknown. It could be speculated that she did not require assistance and did not have any doubts about her decision. Furthermore she may have viewed abortion as a difficult experience but just something that had to be done at the time. Equally she may have had a fear of being judged, again this is just speculation. But this case and the other examples outlined, does highlight the diversity of experiences of and responses to abortion for women in Ireland. Other societal influences emerged as aspects for reflection in the interviews including:

> Megan referred to the *"criminalisation of abortion in Ireland"* and *"the cultural introject of the woman as seducer / temptress….you dishonour and shame your gender"*

Clare described the potential effect of witnessing public demonstrations of the abortion debate *"the rallies for and against must be so damaging to those women no matter what side, there is judgement in both"*

To conclude this theme, Frank paints a vivid image of the effect of secrecy describing it as "*like closing up the pressure cooker and leaving it on, it's like, it's like….the pressure builds and just erupts into other areas of their lives"*.

4.5 Summary

The results from the interviews draw attention to the complexity of an abortion experience. The participants willingly offered examples from clinical material to demonstrate the impact, presenting issues and ways of working with women that have undergone abortion. The therapist's views and examples also illustrate that an abortion experience can impact on varied aspects of a woman's internal and external world. In contrast, the data also revealed that for a minority of the women their abortion did not result in negative psychological effects. The impact of living in Ireland evoked an emotive response in many of the interviews, as they have seen firsthand its influence in their client work.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.1 Introduction

The aim of this study is to gain a more insightful understanding of the Irish woman's subjective experience, particularly considering the issues of stigma, culture and societal attitudes, which are listed in the research as instances where abortion may have a negative impact. Psychotherapists witness first-hand their client's individual experiences and create the space where anxiety, distress and difficulties can be acknowledged and explored. As previously outlined, there is an absence of literature that specifically pertains to Irish women. These findings will present a depth of understanding from the therapist's experience and observations of the issues that present for these women from a psychotherapeutic perspective.

This chapter will explain and interpret the findings from the data with specific reference to the themes that were extrapolated from the interviews using thematic analysis. The themes presented in the results section will be discussed in relation to previous theory and literature and the research question. The implications of the results will be explored and the strengths and limitations of this research will also be examined. The prominent themes are:-

- The therapist's observations and understanding of the impact of abortion on Irish women
- The issues that present in client work for Irish women post abortion as understood by the therapist
- The therapists understanding of the perceived impact of the societal influence that is specific to Irish women

5.2 The therapist's observations and understanding of the impact of abortion on Irish women

One of the participants proposed that "*an academic study can lose the heart of the human being".* Accordingly these findings provide an illuminative glimpse into the lived experience of these women as understood by the therapist, which distinguishes this study from previous research that did not draw on the experience and knowledge of practicing psychotherapists. The discussion of this theme will intersect with elements of the results in the second and third themes, as they are mutually intertwined for the purposes of this discussion. This in turn will provide a more considered and comprehensive evaluation of the impact. The participant's depictions of the impact of abortion varied and they attributed a range of feelings and issues that lingered and were unresolved for their clients. In the main, the clients they discussed had undergone an abortion some considerable time prior to them entering therapy, but yet their experience remained with them and presented as an issue. It is important to stress that the therapists are not working in immediate post abortion counselling, but are encountering the medium to longer term impact of abortion on Irish women.

The data indicates that the impact varies in severity and nature and has affected aspects of a woman's life including psychological, intra-psychic, psychosomatic and relational. The participants presented a clinical representation of their observations and referred to lingering feelings such as '*loss*', '*woundedness*', '*fear*' '*guilt*', '*sadness*' and '*mixed feelings'* that continued to impact on their clients. In contrast there were two examples given of women that did not have any negative psychological effects, which would be considered the norm in the majority of the research finding. The research literature on the whole contends that abortion does not cause mental health issues for the majority of women and feelings of

sadness, guilt, regret will remain for a minority of women (American Psychological Association, 2008; Academy of Medical Royal Colleges, 2011). However the findings presented here reflect that an abortion experience has impacted psychologically on the majority of women that the participants have worked with, in contrast with the aforementioned literature. Are the women referred to in the findings 'the minority' for whom feelings remain, or is there more complexity to the issue for Irish women? It is expected that as this discussion unfolds the nuances and specifics that apply in an Irish context will emerge.

Further interpretation of the findings suggests that the particular context of these woman's circumstances may increase the risk of negative psychological effects. Evaluation of the results highlights how women cope by suppressing their experience "*burying it"* and is supported by the literature (Brien and Fairbairn, 1996; Loader, 2010). For these women, their experience and subsequent emotional response remains unresolved at some level. Suppression of the abortion experience and resulting responses functions on two levels of the psyche, as both an intrapsychic and interpersonal conflict. The experience is separated from consciousness to protect against the painful emotions, utilising denial as a defence mechanism to detach from these feelings. The ambivalent feelings that were articulated also highlight, the underlying unconscious processes contained in the responses. However as the findings illustrate these feelings re-emerged, causing emotional distress and difficulties in integrating the experience. The deeper unconscious processes operating for these women were not explicit in the findings, as each experience is unique to the individual. Specific clinical case studies would contribute a deeper appraisal of this phenomenon. Nonetheless the deeper unconscious repercussions that, according to Estés hinder a woman's ability to respond to feelings and emotional events are inferred from these findings (2008).

An abortion is also consciously concealed to avoid negative responses or condemnation from others. This finding is consistent with other studies which found a relationship between concealment due to abortion stigma and increased psychological distress (Major and Gramzow, 1999). Another significant finding from the results illustrates how the women's experience has impacted on relationships, which is pertinent in the discussion of denial and its ensuing effects. There were examples given of perceived conflicts with significant others and family members because the women felt unable to disclose their abortion. The adverse impact on relationships was not emphasised in the literature and may be a finding that requires further research. However if it is placed in the context of the effects of enforced secrecy, it is then consistent with the literature (Fletcher, 1995; Shellenberg, 2010 and Kimport et al. 2011). Women feel forced to conceal their experience for fear of negative appraisals both internally and externally. The positive aspects of concealment such as maintaining social status and relationships found in the literature were not reflected in these findings. It can be hypothesised from these findings that there are negative consequences for relationships due to concealment and repression of an abortion experience. This is a significant finding, as this correlates with instances highlighted in the literature that contribute to psychological distress.

The findings also suggest that there are implications for women on a psychosomatic level, in terms of how they perceive themselves as women, their body image and their sexuality. One participant described how her client felt her body had let her down by getting pregnant in the first place, how she then feels about her sexuality must be a further consideration. Body image involves perceptions, emotions and the physical sensations of and about the body and is affected by emotional and physical experiences and is influenced psychologically and

culturally. At a cognitive level, self image is exclusively referenced in relation to abortion stigma as possibly having negative consequences on self image and self worth (Cockrill and Nack, 2013). But it is hypothesised here that unconscious processes are operating at a deeper level for women that have undergone an abortion. The negative emotional responses that do not find an outlet may be experienced somatically. The literature elucidates examples of woman's unconscious conflicts in the abortion experience, which influence how she perceives herself as an embodied self. In more general terms this finding is not supported in the literature. There is a gap in the research on the impact of abortion on the body self and the findings of this study suggest it feature in future research.

Solely based on these findings, it would be disingenuous and controversial to extrapolate and suggest that there is a relationship between abortion and negative mental health outcomes for Irish women. This research could not assess or measure any contributing or contextual factors that would be considered a risk to mental health, such as previous mental health history or personal characteristics and circumstances of the clients. Furthermore this research is based on the participant's observations and interpretations of their client's issues. Nonetheless this theme reflects the complexity of responses to the experience and although the clients may not have a psychological disorder that can be measured, perhaps their emotional distress as outlined compares to the "softer" responses that Thevathasan referred to (2012, para. 12). On deeper reflection the phrase "softer" is unhelpful in this context and implies an underestimation of the potential negative effects for these women.

5.3 The issues that present in client work for Irish women post abortion as understood by the therapist

It is difficult to isolate or characterise presenting issues from the findings, as they were discussed by the participants in general terms of their client's emotional distress, within a process of working through lingering emotional responses connected to their abortion experience. One issue consistently surfaced in the results, that is, the acknowledgment of loss and sadness as legitimate responses to abortion. This is well supported in the literature and was considered by the participants an important process for their clients, to work towards integrating and healing their experience. The complexity of loss in this context was also evident in the findings. Feelings of sadness and loss are acknowledged in the literature as the most common post abortion responses, and also listed as the emotions that may remain for some women, contributing to adverse psychological effects (Brien and Fairbairn, 1996; Fine-Davis, 2007; American Psychological Association, 2008; Academy of Medical Royal Colleges, 2011).

Analysis of the results and the corresponding literature suggests that there are a number of contributing factors to the manifestation of this loss. In the first instance the loss is unconsciously perceived by the women as socially negated, as portrayed in Claire's example of the client that could not be overtly sad (Worden, 2009). Val and Maria's examples portrayed the loss that continued to be felt in the soma and the psyche respectively, particularly at significant anniversaries. Furthermore, Frank referred to the symbolic loss of future hopes and desire and what that represents for the women he has worked with. There are hopes and wishes that may never materialise for some women who chose to have an abortion at a given point in time and later in life may not have a pregnancy wish fulfilled

(Davies, 1997; Needle and Walker, 2008). The ambivalent and conflicting feelings that accompany the decision to have an abortion are reflected in the results and the literature, particularly in the terms of loss. Claire described the loss and sadness that "*goes underground, that's what affects people very badly".* The ambivalent conflict in the mourning process that Freud (1917) posited can be applied in this context. Evidence of the suppression of the feelings and experience has already been examined, but this also provides insight into this complicated and deferred loss affect, that surfaces as emotional distress across different aspects of a woman's life. Doka's (1989) model of disenfranchised grief provides a framework from which to acknowledge and understand the woman's lived experience and work with her in a process of healing the loss.

The benefits of emotional disclosure expressed through the therapeutic relationship are clearly apparent in the findings and is consistent with the literature (Abelin-Sas, 1992, Major and Gramzow 1999; Loader, 2010). The results illustrate that all the therapists worked with their clients to mourn the loss, through a ritual intervention and as part of a grieving process (2008). The use of a ritual is significant as a woman is not afforded an opportunity to perform any sort of ceremony or ritual for the foetus after the abortion, unlike in some Buddhist cultures where there is a ritual of mourning for abortions (Abelin-Sas, 1992). The clinical examples that formed an integral part of this theme, typified the complexity of the issue for women in how it presents in the therapeutic space. The literature has outlined the many different aspects and nuances associated with abortion and the women's lived experiences further demonstrate the complexity of the issue. The vignettes provided a glimpse into what was a longer process of work in the therapeutic relationship. Additionally they provide an opportunity to deepening understanding from a psychotherapeutic

perspective. A recurring theme across the literature was the need for a woman to have her experience validated, not censored by others and being able to share a stressful life event in a supportive environment (Davies, 1991). This was well supported in the findings and enabled the clients to work through and let go their unresolved feelings. These clients were able to do so in the non judgemental therapeutic space and it is not known if some were able to discuss their experience outside of that. Perhaps if women were more readily afforded the opportunity to discuss their both their abortion decision and experience, their burden have been eased at an earlier stage?

The findings suggest that in terms of loss, many of the women were negatively affected in the longer term which is consistent with the limited research on the longer term effects of abortion (Adler, 1975: Goodwin and Ogden, 2007, Dykes, Slade and Haywood, 2011). This study underlines this as an area that could benefit from further research internationally and more specifically in Ireland, considering the particular circumstances that Irish women face. The next theme will extrapolate further from the findings in this regard.

5.4 The therapists understanding of the perceived impact of the societal influence that is specific to Irish women

It was significant in the findings that this theme evoked quite an emotive response and interestingly the type of language used by the participants became more expressive. The findings draw attention to the historical influences of the Catholic Church, the societal attitudes to women and their legacies that still resonate today, as was apparent in all of the narratives. This is not surprising, considering the current prevalence of abortion as a topic

across many media platforms in Ireland. It is fair to question if this might have introduced a positive bias in the narratives, but the examples given of client work demonstrated the reality of the negative impact of the societal influence in Ireland. This theme also surfaced in different guises throughout all of the themes in the results. The main aspects that were extrapolated from the findings were the perceived negative effects of secrecy and abortion stigma, which is consistent across much of the literature. These findings are even more significant, considering that abortion stigma, living in a culture where abortion is prohibited and low perceived or anticipated social support for the abortion decision are listed as three of the risk factors, that impact negatively on mental health. A number of authors and professional bodies have highlighted this dearth of research, which was a contributing factor to undertaking this study.

Clare and Tyrrell (1994) link the factors of stigma, religious and cultural context, the need for secrecy and travel abroad, as issues for consideration and further research on the potential impact on mental health for women that live in Ireland. It is hypothesised here that the feelings of shame and guilt may be amplified in this context. What outlet for these negative emotions do Irish women have, particularly as their experience is confounded by enforced secrecy and a sense of alienation? It can also be hypothesised as with any stressful life event, negative feelings which cannot be released, are retained in the psyche and the body's nervous system and musculature and may be adversely experienced psychologically and somatically (Levine, 1997).

It is difficult to separate the effects of stigma and secrecy, as they are strongly associated in the literature and reciprocal in nature. The results portrayed the internalised, felt stigma and

the perceived societal stigma amongst the examples referenced (Cockrill and Nack, 2013). This resulted in the women feeling isolated and unsupported and unable to share their experience. Shellenberg et al., (2011) examined the existence and depth of abortion stigma in a study across five countries and found that it was similarly perceived, but more evident in countries with more restrictive abortion laws. The findings in this study strongly suggest that this also pertains to Ireland where abortion is preserved in the law as a criminal act. Abortion is also a subject that falls within the realm of taboo, and mere mention of it can evoke levels of anxiety and strong emotions, thereby exacerbating the stigma. It is somewhat ironic that the stigma, that pro-life campaigners have advocated, is itself a negative influence on mental health outcomes.

Fletcher's (1995) hypothesis that there is a relationship between women's silence and the public debate on abortion, that further inhibits them sharing their experiences, resonates in these findings. Silence also has complex functions in this context. It can be seen to protect against negative appraisals and to protect loved ones from becoming upset were they to find out. Equally conflicting feelings do not have to be expressed alongside of the frustration of not believing, that there is a supportive environment in which to talk openly (Fletcher, 1995). Megan's example in the findings described one woman's very recent experience of journeying to England, her subsequent return and meeting with her therapist as the only option for her to discuss her abortion. This case highlighted the continuing, difficult circumstances in Ireland, that force a woman to travel abroad and the subsequent fear of not being able to tell anyone of their experience. It could be speculated, as is consistent with the available literature that this woman may be negatively impacted in future life, because of the

enforced secrecy and perceived stigma. Silence and enforced secrecy was a recurring feature across all of the themes and the negative effects were emphasised in all of the findings.

This study has provided an opportunity to consider if the societal influence that pertains to abortion in Ireland has negative implications for mental health outcomes. The findings in this research on the effect of stigma, purposeful concealment and secrecy support this hypothesis. The premise that it is these factors, not the abortion *per se* that contribute to psychological distress (Clare and Tyrrell, 1994) is not fully apparent, but some correlations can be drawn from the findings. This is an area that would benefit from a more in depth study that measured and assessed other contributing factors and used a much larger sample with appropriate comparators. Paradoxically the stigma, taboo and secrecy are conceivably evident in the paucity of research on this subject for Irish women.

5.7 Strengths and limitations

The researcher was conscious of the limitations within this study. The sample size was small and as such the findings cannot be generalised, but this also allowed for a more in depth exploration of the subject matter. As with other studies and research into the effects of abortion there are many confounding variables that could not have been measured or accounted for. The fact that the clients were already in therapy could suggest that their emotional difficulties were present, prior to their abortion and therefore their prior mental health may have been a risk factor for future psychological distress. Equally psychological difficulties are rarely attributable to a single event or factor but are often part of a complex

psychological process that includes a myriad of factors, which are difficult to discern in a qualitative study.

Abortion is a subject that is difficult to present objectively without the influence of personal beliefs and values, and the researcher was mindful of this throughout the presentation. Nonetheless for the researcher this was viewed as a strength in the study, ensuring that it objectivity and impartiality were maintained. Similarly the same can be said of the participants and it is not fully clear if their beliefs negatively influenced on their input. However their vivid and informative accounts provided a therapeutic perspective that has heretofore been lacking in the research. This further distinguishes this research from previous research by providing an enlightening glimpse into the lived experience of Irish women.

5. Recommendations

This study has mentioned the lack of research that pertains to Irish women and the subsequent strong suggestions for it to be carried out. This study provides a small snapshot of the impact of their abortions and their subjective experiences. It is an area that in its entirety requires further research. The issues of abortion stigma, perceived lack of social support, living in a country where abortion is prohibited are all proven factors that negatively impact mental health outcomes and such research should be undertaken. As highlighted there is a lack of research on the impact of abortion from a psychosomatic perspective and its omission is questionable. This study also underlines, that the longer term effects of abortion on women would benefit from further research internationally and more specifically in Ireland.

5.5 Conclusion

The most recent literature reviews, evaluations and meta analysis in general concluded that abortion does not cause mental health problems for the majority of women (Charles et.al, 2008; Major et al., 2009; Academy of Medical Royal Colleges, 2011; Kendall, Bird, Cantwell and Taylor, 2012). They also highlight instances and specific risk factors that may contribute to psychological distress, that have been articulated throughout this study. The findings suggest that these instances such as stigma, cultural attitudes, enforced secrecy and a lack of perceived support are an integral component of the Irish woman's emotional response to an abortion experience and warrants further research. The complexity of abortion for women is evident in the findings. It is multi-layered and influenced by many aspects of a woman's life, which was illustrated through the participants sharing of their client work and knowledge.

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APPENDICES

Appendix A

Semi structured interview questions

1) What drew you to this type of work?
2) Can you tell me a little about your experience of working with clients that have had an abortion / s
   - Did the issue come up as an initial presenting issue or come up later through the course of the work?
3) Can you tell me what sort of issues / themes emerged in your work with these clients?
4) What is your understanding of these issues from a psychotherapeutic perspective?
5) What is your sense of how these issues relate to their abortion experience?
6) How did the client/s describe themselves at the time of their pregnancy and abortion decision?
   - Would you have a sense of their emotional landscape at the time of their abortion decision
7) In your opinion how have they incorporated their experience in the longer term?
8) Much of the literature focuses on the psychological impact of abortion with little consideration given to the body and abortion, in your experience with these clients has this come up in the work?
9) There is an absence in the literature on the psychological impact of an abortion for Irish women, particularly considering the social / cultural discourses, stigma, having to travel abroad and secrecy, with this in mind what is your experience of your clients from this perspective?
10) How do you feel living in Ireland has impacted on both their decision and their experience?
11) What are you aware of in your own personal process when working with these particular clients?
12) Is there anything else you would like to add from your experience that has not been touched on so far?

Appendix B

INFORMATION FORM

My name is Bevin Herbert and I am currently undertaking an MA in Psychotherapy & Counselling at Dublin Business School. I am inviting you to take part in my research project which is concerned with the presenting issues of Irish women post abortion. There are a multitude of studies and research on the psychological effects of abortion on women, but few that specifically relate to Irish women. The aim of this study is to gain a more insightful understanding of the Irish woman's subjective experience, particularly considering the issues of stigma, culture, travel to another country and societal attitudes that may affect her.

What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being an accredited psychotherapist. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature_____

Date / /

Appendix C

Consent Form

A psychotherapeutic exploration of the presenting issues of Irish women post abortion

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have ample opportunity to ask questions all of which have been satisfactorily answered. ☐***Yes*** ☐***No***

I understand that my participation in this study is entirely ***voluntary*** *and that I may withdraw at any time, without giving reason.* ☐***Yes*** ☐***No***

I understand that my identity will remain confidential at all times. ☐***Yes*** ☐***No***

I am aware of the potential risks of this research study. ☐***Yes*** ☐***No***

I am aware that audio recordings will be made of sessions ☐***Yes*** ☐***No***

I have been given a copy of the Information Leaflet and this Consent form for my records. ☐***Yes*** ☐***No***

Participant _____ _____

Signature and dated ***Name in block capitals***

To be completed by the Principal Investigator or his nominee.

I the undersigned have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them.

_____ _____ _____

Signature **Name in Block Capitals** **Date**