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**“Not another patient through the revolving door”: A case study
analysis of six women’s experiences with pregnancy terminations
in New Zealand.**

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Psychology
at the
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by

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Abstract

This thesis investigates an under-researched and largely ignored area in New Zealand, specifically six young women's experiences of pregnancy termination in a New Zealand context. The aim of this research is twofold: to investigate the interconnection between intimate relationships and pregnancy terminations, and to describe and analyse the experiences of quality of care provided in New Zealand pregnancy termination settings.

This research is conducted using a narrative methodology that allows each participant to have their own unique 'voice' and to offer valuable and rich insights into their personal experiences of pregnancy termination. Six participants were selected who met the criteria of being under 25 years of age at the time of their terminations. These participants were interviewed individually on three separate occasions using a qualitative semi-structured interview schedule with themes that included life before falling pregnant, culture and religion, intimate relationship pre- and post-termination, intimate relationship education (if any) provided at school, interaction with health professionals, accessibility, experiences on the day of the procedure, and participants' advice for young women contemplating a termination.

The findings from this thesis demonstrate a plethora of consequences for intimate relationships and the delivery of quality of care throughout the termination process. In terms of intimate relationships, the dissolution of the 'honeymoon period' exacerbated issues for women undergoing terminations. The quality of the relationship was found to be an important contributor to decision-making, particularly when the intimate partner was invited to share this responsibility. Problems arose in those relationships where there were incongruent experiences concerning the termination — for example, when one individual in the relationship was coping but the other was not. Irrespective of the quality of the relationship one key finding is that terminations appear to have a significant negative impact on future relationships. Interestingly, some participants chose to conceal their terminations from future intimate partners when then knew their partners were opposed to pregnancy terminations on ethical grounds.

This thesis also highlights the considerable barriers to accessing termination clinics because they are located in the main centres and required most participants to travel to these clinics. Many participants struggled to ‘get a foot in the door’ and this often resulted in delayed entry to the service. Participants were aware of the role of the health professionals as the legal gatekeepers to the termination process and this led some to conceal their emotions, further heightening their stress on the day of the termination. The participants’ experiences of simply being a ‘number’ and part of the ‘revolving door’ process contributed towards their negative perceptions about, and experiences of, quality of care. The combination of their desire for but absence of tangibility, coupled with the non-alignment of participants’ expectations with the quality of care service they received, led some participants to have negative experiences of the termination process.

The narratives that have been offered by the six young women who have had a termination provide valuable insights into, and reflections about, their personal experiences with a legal process that for many New Zealanders still remains ‘behind closed doors’.

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Foreword

The intent and spirit of this thesis was not designed to engage in a debate of the morality of undergoing a pregnancy termination. It is hoped that the results obtained from this research are not used in a manner to advance either pro-life or pro-choice causes. To do so would detract from the core objectives of this research: to modestly command attention to an area of research in New Zealand that has largely been neglected. At the outset, such transparency and openness within this research has revealed contexts and circumstances that may determine how young New Zealand women negotiate decision-making and life after termination. May respectful, passionate, and educated conversations take place, in ways that value dignity, respect, social justice, equality, tolerance, diversity and freedom – concepts that New Zealand was founded on and are simultaneously imbedded in Te Tiriti o Waitangi.

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Chapter One: Introduction

Pregnancy terminations are a relatively common, albeit controversial, procedure that has occurred legally in New Zealand following the introduction of the Contraception, Sterilisation and Abortion Act in 1977. Historical records, anecdotes, and other written accounts have revealed that the practice of illegal terminations have occurred long before the passage of the 1977 Act. It is predicted now that one in every four New Zealand women will undergo a pregnancy termination during their lifetime, leading researchers to question what currently is known, and what should be known, about this experience for New Zealand women. Much engaged and lively, but often ill-informed, debate subsequently has occurred surrounding the legitimacy of pregnancy terminations and their impact on personal and societal wellbeing. Although this thesis does not investigate the morality of pregnancy terminations, it does document and analyse the experiences of six young women who have decided on a pregnancy termination in New Zealand. In doing so, it explores how intimate relationships and quality of care in a termination setting affects these women's overall experiences and lives and, therefore, their wellbeing.

Despite the historical and contemporary controversy surrounding pregnancy terminations, intimate relationships and quality of care components have received scant academic attention in New Zealand's psychological literature. Where mention is made of pregnancy terminations this invariably has emphasised the relationship between pregnancy terminations and subsequent mental health outcomes. Preoccupation with these associations has meant that fundamental questions concerning how a pregnancy termination might effect current or future relationships, how an intimate relationship might effect decision-making for termination, and how 'quality of care' contributes to the overall experience of pregnancy termination for women have all but been ignored.

The purpose of this study is to address these fundamental questions and to situate this analysis within the local New Zealand context. This is vitally important because much of the previous research has involved analysis of international

populations, with very little attention paid to applying this specifically to a New Zealand framework. This is evident particularly for the bi-directional relationship between pregnancy terminations and intimate relationships. Overseas-based studies have very different historical, cultural, and socio-political contexts that are likely to influence the relationship between these two phenomena. New Zealand is a unique nation. It has its own history, it has an indigenous population, and it seeks to find its own solutions to its own problems. In terms of ‘quality of care’, there is limited research that explores this broad concept and the conditions (and assumptions) that underpin this. Prior research that has highlighted barriers in terms of timeliness and geographical accessibility is presented and then compared with (and analysed in) this research. This thesis seeks to provide new understandings about pregnancy terminations and to contribute to, and to expand, the paucity of New Zealand based literature in this long neglected area of research.

This thesis argues that pregnancy terminations rarely occur in a vacuum, that invariably there are other social actors involved in the process. Furthermore ‘quality of care’ can affect a termination experience, either positively or negatively. The combined failure to consider these significant components of pregnancy terminations leads to inaccurate comparisons (and assumptions) being made between pregnancy terminations and their contribution to adverse mental health outcomes. It is further argued that by understanding the complexity of intimate relationships in and around the time of pregnancy terminations, health professionals and the wider public can better provide supportive and holistic support mechanisms, if and when required.

This study has chosen to analyse the experiences of younger rather than older women because of the disproportionately high number of young women (under 25 years of age) presenting for a pregnancy termination in New Zealand. As young women often are in a formative stage of their lives, this research will reveal aspects of their individual circumstances in ways that enhance our understanding of the events prior to, during, and following the termination process itself.

Thesis structure

Chapter One examines the rationale for the researcher choosing this topic for further investigation. It also examines possible reasons why young women seek a termination, describes the progression of pregnancy termination legislation over time, and presents data relating to terminations performed in New Zealand. Collectively, this chapter explains the prevalence of terminations in New Zealand and advances reasons why some women seek to pursue legal terminations.

Chapter Two traces the development of pregnancy terminations in New Zealand for both Māori and Pakeha cultures. This provides an historical and contemporary framework for understanding not only the prevalence of terminations but also associated attitudes about terminations per se. Later, the chapter examines the literature surrounding intimate relationships and its association with pregnancy terminations. It also provides a detailed description of the factors that have been found to contribute to ‘quality of care’ and evaluates the specific components that are particularly important in pregnancy termination settings.

Chapter Three outlines and explains the methodology for the research subsequently adopted and described in Chapters Four and Five. It also provides brief biographical information about each of the six participants, outlines the procedures and processes surrounding participant recruitment, describes the interviewing schedule, and discusses ethical considerations. The researcher has included a commentary on the use of reflexivity and has explained the presence and role of the researcher in the interviewing and analysis process. This chapter details the *how* aspect of this research, taking into consideration explanations of narrative theory and the decision to adopt a case study approach to this research topic.

Chapter Four provides a descriptive account of the participants’ narratives. Particular attention is paid to the participants’ lives before becoming pregnant, their decision-making processes and associated factors or circumstances, the quality of the participants’ intimate relationships, intimate relationship education

(if any) provided at school, how the participants' relationships were or were not affected by the termination, culture and religion and, life after termination.

Chapter Five provides a further narrative account in relation to participant experiences of quality of care. This section will review partner presence at termination clinic, interaction with first health professional, interaction with sonographer, interaction with pregnancy termination social worker/counsellor, encounters with health professionals on the day of termination, waiting room atmosphere, clinical quality of care and, participants' advice for women contemplating a termination.

Chapter Six undertakes a thematic analysis across participants' narratives in order to identify common emergent themes. This chapter presents a series of themes in relation to intimate relationships, quality and care, and how this influenced women's overall experiences of pregnancy termination. International and national research is drawn upon and situated in the context of the results discussed in Chapter Four and Five.

In the final chapter, Chapter Seven, the conclusion is reached that, contrary to prevailing beliefs and theories claiming that intimate relationships are affected by a pregnancy termination, it is the quality of care that women receive that contributes to more positive experiences of pregnancy terminations. Specific aspects of quality of care are highlighted in order to identify those significant moments that had an impact upon women's wellbeing, either positively or negatively. This thesis further reveals that, in contrast to the prevailing research literature, pregnancy terminations have little if any impact on future relationships. When pregnancy terminations do have an effect on future relationships it is due primarily to the women's decision to conceal past terminations. The thesis then is advanced that although pregnancy terminations have the potential to influence current intimate relationships, it is the quality of care that women receive that has a profound impact upon the overall termination experience.

Background

This section provides a context for this research. Owing to a variety of factors, the topic of young New Zealand women's experiences with terminations has long been of interest to me.

Although originally born and raised in the South Island of New Zealand, as a teenager I moved with my family to Palmerston North in 2007. Statistically, Palmerston North is one of five regions in New Zealand that have the highest rates of teenage pregnancy (National Institute of Demographic and Economic Analysis, 2014). Shortly after completing my secondary schooling a couple of friends confided in me that they had fallen pregnant. I helped my various friends to work through the decision-making process, making sure that I was there for them to talk to rather than imposing my own opinions. However, I later learnt how hesitant some of my friends were in confiding in me regarding their decision to seek a termination. It appeared that they had difficulty balancing the need of talking to someone versus gauging my personal stance on pregnancy terminations. Reflecting on this, during my undergraduate studies I came to understand that young women who undergo pregnancy terminations might have limited social support due to social stigma and that this subsequently impacted upon their decision-making and adjustment post-termination. The area of pregnancy termination highlights my long standing interest in, and concerns for, social justice, equality, and discrimination.

Another catalyst for the topic of pregnancy terminations came when travelling on holiday to Napier, a small town in the Bay of Plenty, where I noticed a group of protestors outside the hospital and on the main road leading out of Napier. They waved pickets with words and images, and received approving toots from passersby. Meanwhile I watched as young women attempted to pass through them in order to gain access to the hospital. It was here that I was again reminded of the need to research the experiences of young woman who have had a termination. Preliminary investigation into this area led me to conclude that it may have been that the social stigma and controversy surrounding this topic has led to relative lack of research into this important topic.

Whilst completing my undergraduate degree I also began my career working in youth and community mental health. As a youth worker, and then later as a youth therapist, I became increasingly exposed to the circumstances that led some youth towards pregnancy termination. As part of my role was to refer women to appropriate services when in need of assistance, I began to explore how the termination service operated in New Zealand.

I suggest that because pregnancy terminations have been legalised in New Zealand since 1977, (for nearly 40 years), young women's experiences are overdue for research. This study will provide both the readers and myself with privileged access to a deeply personal experience. Whilst the topic of pregnancy terminations in New Zealand has lessened *somewhat* in hysteria with the passage of time, there still is pervasive social stigma that can have an impact upon young women in various and unique ways. In light of this context, I wish to thank my participants for their strength and willingness in sharing their deeply personal stories with me.

Derived from my work alongside young women considering a pregnancy termination, I will refer to the induced death of a fetus as a pregnancy termination rather than abortion. This is due to the intense dislike of the word 'abortion' by former clients as well as this preference being stated clearly by almost all of the participants in both my honours dissertation and thesis. Accordingly, for the duration of my thesis, out of respect for these young women, I have labeled this practice as a 'pregnancy termination'.

Why do some young women choose to have a pregnancy termination?

There are multiple factors cited in the literature that may lead some women to choose a pregnancy termination (Coleman, 2007; Lauzon, Achim, Achim & Boyer, 2000; Tornbom & Moller, 1999; Trinh, 2012). Often the reason is underpinned by the reality of the pregnancy having an adverse impact on the life of the woman and/or those around her (Kirkman, Rowe, Hardiman, Mallett & Rosenthal, 2009). Other, more specific explanations, can include poverty and/or low educational achievement/attainment; relationship problems – casual, new, or

abusive relationship; lack of support from partner, the belief that the woman is too young or not ready for motherhood; the family is seen to be complete and no more children are wanted; genetic abnormalities; and sexual assault (Costa, Jessor, & Donovan, 1987; Kirkman, Rowe, Hardiman, Mallett & Rosenthal, 2009; Trybulski, 2005;). The two most common reasons cited across various studies for younger women choosing a termination were that they were not yet ready for motherhood and that there were relationship problems (Bankole, Singh & Haas, 1998; Broen, Moum, Bodtker & Ekeberg, 2005; Kirkman, Rowe, Hardiman, Mallett & Rosenthal, 2009). As noted by Costa, Jessor and Donovan (1987) the decision to terminate follows on from a series of earlier decisions about whether to use contraception, what contraception to select or whether the contraception works, and then the decision surrounding the pregnancy itself. The decision to terminate therefore can often reverberate following a string of earlier decisions or contraceptive failures (Costa, Jessor & Donovan, 1987; Tinh, 2012). Ultimately, like other important life decisions, the reasons for termination are unique to the individual and their particular circumstances.

The decision to terminate is often situated within competing preferences that mean that decision-making is not clear-cut. Harris and Mills (1985) explain the *Theory of value conflict* whereby one's identification with religion often affects one's attitude to pregnancy terminations and associated decision-making. The decision to have a pregnancy termination, Harris and Mills (1985) claim, invariably involve the resolution of internal conflicts, specifically the duty to be responsible and to care for others and the freedom to live one's life freely (Harris & Mills, 1985). Although these values are often in tension, they can co-exist within individuals as Allanson and Atsbury (1995) have noted. For young women who are religious, the decision to terminate their pregnancy occurred in the knowledge that others would suffer if the pregnancy continued (Allanson & Atsbury, 1995). Furthermore, they found that church attendance and interaction with like-minded religious individuals rather than religious affiliation positively correlated with pro-life attitudes (Allanson & Atsbury, 1995). For young women faced with an unwanted pregnancy, regardless of their religious affiliation, pregnancy terminations have the potential to strain internal values making the decision-making process all the more difficult and complex.

Allanson and Atsbury's (1995) research has demonstrated that some women who terminate a pregnancy do so on the grounds of 'caring' and 'responsibility' towards others. In this instance, such women terminate due to the pregnancy leading to suffering for others, a concern that their partners might not cope, or concern that they would not be the mother they envisioned that they would be – kind, loving, and unconditional. More recent research by Jones, Frohwirth and Moore (2008) suggests that women's decisions to terminate can often be due to their wish to be a 'good parent'. This can be due to their desire to secure positive financial futures for their current children to ensure that these children would continue to receive the stable loving family, and the financial security necessary (Jones, Frohwirth & Moore, 2008). Ultimately, and sometimes in marked contrast to popular but unfounded societal myths, decision-making often involves considering the wellbeing of significant others in the women's lives.

Importantly, some young women who find themselves with an unplanned and unwanted pregnancy feel they have little choice but to consider termination. These women may feel this way due to a myriad of reasons that include: intimate relationship abuse, financial reasons, the absence of any desire for children, social and emotional isolation, or the contribution of others (Trybulski, 2005). The perception of choice is very much dependent on the young women's present and future environment as well as her personal, social, emotional, and financial capabilities and circumstances (Trinh, 2012).

Here and now: New Zealand pregnancy termination legislation

Pregnancy terminations have endured a long and expansive legislative history in New Zealand. Like other commonwealth nations, New Zealand inherited its termination statute legislation from England (Sparrow, 2014). The first legislative statute to regulate pregnancy terminations in New Zealand was the 1867 'Offences Against The Person' Act (Sparrow, 2010; 2014). Thereafter, it was illegal for any person to supply or use an instrument or any other means for the express purpose of inducing miscarriage in a woman. This legislation applied to both the 'abortionist' and the pregnant woman herself should she perform self-termination (Sparrow, 2014). The 'abortionist' or the woman who induced her own miscarriage were each liable to a term of life imprisonment or between three

and ten years, with or without solitary confinement (Sparrow, 2014). Supplying means to induce a pregnancy termination carried with it a sentence of up to three years imprisonment (Sparrow, 2014). The 1893 Criminal Code Act subsequently replaced the 1867 Act, with a new maximum sentence of seven years introduced. However, this provision applied regardless of whether the woman was pregnant or not (Sparrow, 2014). Under the earlier (1867) statute, only women with a confirmed pregnancy who induced a termination were liable for prosecution (Sparrow, 2014).

The 1893 Criminal Code Act remained in force until the Crimes Act of 1961, which was in most respects a copy of the former Act. Although England had allowed socio-economic circumstances to be considered at this time New Zealand did not allow such considerations (Sparrow, 2010; McCulloch, 2013). This remained until the arrival of the Contraception, Sterilization and Abortion Act in 1977. The 1961 Crimes Act states that “everyone is liable to imprisonment for a term not exceeding 14 years who causes the death of a child that has not become a human being in such a manner that he (she) would have been guilty of murder if the child had become a human being”(McCulloch, 2013, p. 157). However, part two of section 182 also states that “no one is guilty of any crime who before or during the birth of any child causes its death by means employed in good faith for the preservation of the life of the mother” (McCulloch, 2013, p. 157).

As Australia and other Commonwealth nations began applying more liberal attitudes to legislation, as well as the rise in protest groups, New Zealand began to shift towards less stringent legislation and contraceptive information increasingly became available for young people (McCulloch, 2013). The 1977 Act not only allowed terminations to be authorised after having full regard to the rights of the unborn child but also permitted terminations to be conducted at licensed institutions, provided that two certified consultants (General practitioners/gynecologists) had agreed to the termination (McCulloch, 2013). The woman herself also has to sign a document attesting that she agrees to the termination. In the lead up to the procedure women were required to have at least one counselling session with a social worker or counsellor to assess the young women’s readiness and reasons for the termination (McCulloch, 2013). This

counselling opportunity also helped women with decision-making, problem-solving, and education around the nature of the procedure (McCulloch, 2013). Terminations however, were never legalised for social reasons, that is, not being ready for motherhood, financially unstable, unstable relationships and the like, but were legalised on the grounds that the continuation of pregnancy posed a definite risk to the life or the physical/mental health of the women or any other children in her family (Sparrow, 2010). A further provision stated that termination was legal when the unborn child has a substantial risk of having a serious physical or mental disability (McCulloch, 2013). Terminations were legal (subject to the provisions in the Act) until 20 weeks gestation (Sparrow, 2010).

Currently, the 1977 Contraception, Sterilisation and Abortion Act continues to govern pregnancy termination practice in New Zealand (Sparrow, 2010). Notably, the medical community possesses significant authority in determining whether a young woman is able to have a termination due to social reasons (McCulloch, 2013). In some cases, this can depend on the moral belief systems of the medical community which has led some doctors to refuse to consent to the woman's termination and/or not to refer to another practitioner (McCulloch, 2013). If agreed to by the practitioner, women then sign a document that permits the termination and identifies and explains the decision due to danger to mental health (McCulloch, 2013). Since 1977 numerous attempts have been made to tighten the connection between the legislation and current practice but this has not been fully successful, Sparrow (2010) argues that this is because the controversy surrounding pregnancy termination continues to prevent the alignment of legislation with contemporary social and cultural contexts.

New Zealand pregnancy termination statistics

The purpose of this section is to situate pregnancy terminations into a New Zealand context. The statistics that will be provided help to convey a comprehensive overview of those women who presented for pregnancy terminations over the period 1980-2013. However, statistics comparing the termination rate amongst low fertility and developed countries are not presented within this thesis due to the inherent multitude of factors, legal, moral, and social, that produce international variation (McCulloch, 2013). Nevertheless, it is clear

that pregnancy terminations remain as one of the most common medical/surgical procedures in New Zealand with 1 in every 4 New Zealand women having a termination in their lifetime (Abortion Services, 2013).

Of particular importance is the gestational age (see Table 1) and the age at which young women receive a termination (see Table 2). The gestational age is a relevant statistic concerning the 'quality of care' because an increase in duration of pregnancy may represent a 'quality of care' related issue. Accordingly, accessibility factors or other issues relating to the healthcare system may delay women from receiving a pregnancy termination.

As evident in Table 1, the number of women receiving a pregnancy termination at less than 8 weeks gestation has increased from 826 to 2516 during 1991-2013. Overall, it appears that up until the turn of the 21st Century there were proportionately high numbers of women receiving a termination between 8-12 weeks. Presently, the percentage of women receiving a termination between 8-12 weeks has decreased since 1991. However, the percentage of women receiving terminations at 12 and 13 weeks gestation has remained steady since 1991. More generally, it also shows that the number of women presenting for termination between 1991 and 2013 has increased from 11613 to 14073.

Table 1: Number of terminations categorised by duration of pregnancy (weeks) for the period 1991 – 2013 (Abortion Services, 2013).

	Under 8	8	9	10	11	12	13	14+	Total
1991	826	2,662	2,592	2,757	1113	976	272	415	11613
1992	715	2305	2733	2868	1202	935	296	541	11595
1993	418	2121	2704	3246	1373	1155	311	565	11893
1994	350	1969	2741	3527	1792	1420	442	594	12835
1995	351	1633	2354	2919	1436	2322	912	725	13652
1996	351	1613	2559	3560	2898	2316	754	754	14085
1997	449	1757	2747	3799	2987	2064	715	690	15208
1998	574	1923	3189	3436	2323	1913	957	714	15029
1999	775	1948	3047	3502	2496	1935	1030	768	15501
2000	854	2047	3135	3564	2627	2062	985	829	16103
2001	925	1790	2969	3622	2721	2270	1227	886	16410
2002	1129	1751	2773	3820	3019	2633	1300	955	17380
2003	1281	1824	2,710	3882	3456	2903	1494	961	18511
2004	1263	1835	3505	3993	3007	2613	1164	891	18211
2005	1271	1782	2928	3620	3011	2640	1350	929	17531
2006	1526	1843	3012	3,012	2990	2634	1259	941	17934
2007	1478	2413	3558	3,558	3131	2631	478	1022	18382
2008	1687	2875	3743	3,743	2655	2026	438	981	17940
2009	1941	3294	3580	3149	2412	1768	408	998	17550
2010	2168	3836	3316	2601	1993	1346	470	882	16630
2011	1893	3518	3289	2561	1930	1364	400	908	15863
2012	2031	3066	3053	2349	1730	1264	409	843	14745
2013	2516	2735	2683	2251	1571	1169	358	790	14073

Table 2 provides data about different age groups that seek a termination, indicating that women aged under 25 years represent a large proportion. As seen in Table 2, ages 20-24 and 15-19 are the highest and second highest groups respectively. These statistics provide evidence that whilst pregnancy terminations in New Zealand do occur across a range of ages, 15-19 and 20-24 year olds are

represented disproportionately in these statistics. This is part of the reason that I have been motivated to undertake research specifically on youth experiences of a pregnancy termination.

Table 2: Induced terminations registered in New Zealand and categorized by the age of women (Abortion Services, 2013).

	11-14	15-19	20-24	25-29	30-34	35-39	40-44	45+	Total
1991	43	2283	3450	2592	1845	1085	300	15	11613
1992	42	2232	3332	2698	1869	1063	308	22	11595
1993	52	2250	3575	2608	1920	1142	322	24	11893
1994	43	2457	3900	2787	2056	1214	350	28	12835
1995	42	2594	4164	2985	2158	1282	390	37	13652
1996	60	2909	4397	3239	2315	1419	430	36	14805
1997	56	2906	4484	3378	2369	1502	492	21	15208
1998	65	2832	4355	3381	2368	1559	444	25	15029
1999	56	2846	4477	3447	2435	1642	560	38	15501
2000	74	3107	4548	3399	2496	1823	613	43	16103
2001	66	3240	4728	3450	2555	1730	593	48	16410
2002	78	3602	5124	3450	2676	1715	686	49	17380
2003	89	3757	5670	3619	2800	1846	692	38	18511
2004	85	3758	5528	3501	2644	1916	721	58	18211
2005	92	3718	5203	3491	2520	1773	687	47	17531
2006	105	3978	5314	3530	2497	1777	691	42	17934
2007	104	4173	5445	3574	2547	1814	667	58	18382
2008	83	4097	5396	3591	2290	1754	675	54	17940
2009	79	3873	5332	3539	2311	1692	674	50	17550
2010	84	3389	5150	3411	2242	1649	655	50	16630
2011	68	2822	5160	3340	2220	1593	605	55	15863
2012	51	2489	4560	3240	2248	1506	590	61	14745
2013	48	2096	4386	3174	2237	1451	637	44	14073
Total	1565	71408	107678	75424	53618	35947	12782	943	359394

Other variables, such as ethnicity and previous births and terminations, are also important in creating a holistic picture surrounding the women who present for a pregnancy termination. Statistics regarding previous terminations (see Appendix A) demonstrate that the majority of women (between 61.5 and 76.8 per cent) presenting for a termination had no previous terminations. Although the majority of women who present to a termination service requesting their first termination is the largest group, this percentage has decreased from 76.8 per cent to 61.5 per cent during the period 1991 to 2013. Previous life births also reveal that between 1991 and 2013 women with one or two previous children have gradually sought assistance from termination services (from 18.0 to 20.4 per cent and 32.0 to 35.8 per cent respectively) (See Appendix B). This further demonstrates that the demographics of women presenting at New Zealand termination services may steadily be changing.

In terms of ethnicity (see Appendix C), European New Zealanders consistently comprise the greatest proportion of pregnancy termination patients, representing 8,015 of 14,073 terminations in 2013. Māori have consistently been the second highest group across 2002-2013, accounting for 3,459 terminations in 2013. Pacific and Asian ethnicities also have remained fairly similar from 2002-2013, accounting for 1,712 and 2,405 terminations in 2013. These statistics have implications for how pregnancy termination services respond to the ethnic diversity among women seeking their services. Appropriate responses may include training staff in cultural competency, providing access to cultural advisers, and providing a more holistic experience for young women.

This chapter has provided an overview of the thesis, both in terms of the structure and background information related to the topic. Chapter one has also explored the reasons why young women may decide to have a pregnancy termination, and provided an extensive legal history of terminations in New Zealand. The following chapter will examine the history of pregnancy terminations in New Zealand, both before and after terminations were legalised. This chapter will largely focus on an academic literature review of both traditional Māori and Pakeha experiences with terminations as representing New Zealand as a bicultural nation. The literature review will also examine in depth the association between

intimate relationships and terminations, as well as the experiences of quality of care internationally and nationally.

Chapter Two: Literature Review

Whilst Chapter One explored the reasons and legislation behind terminations, Chapter Two focuses on historical experiences of pregnancy terminations in New Zealand. This chapter explores traditional views concerning terminations from a cultural perspective; including both Māori and New Zealand European. The academic literature is examined, with particular attention paid to the association of current and intimate relationships with pregnancy terminations. Further research is examined concerning the experiences of quality of care in pregnancy termination settings. Both international and national research is drawn upon, however owing to the scarcity of research in New Zealand, international research is heavily referred to. This chapter then concludes with a statement of the research objectives.

History of pregnancy terminations in New Zealand

The accessibility and safety of pregnancy termination services in New Zealand has had a long and eventful history. Owing to a combination of restrictive legislation, ‘moral panics’, and social constraints/expectations, such as, marriage, work, and finances, young women in New Zealand historically have experienced limited access to pregnancy termination services (Sparrow, 2014). In the early part of the 20th Century New Zealand women seeking terminations had difficulty finding a clinic with access often limited to knowing someone who could assist in terminations (Sparrow, 2014). Sparrow (2010) offers insight into some experiences where New Zealand women had to travel considerable distance to get to a clinic and, in some cases, as far as Australia.

For early 20th Century New Zealand women, undergoing a termination typically resulted in developing septicemia and statisticians have linked terminations with increased morbidity and mortality rates (John, 1984; Sparrow, 2010). Experiencing a termination was very risky in terms of health and safety with hemorrhaging, death, and infections relatively common risks (Sparrow, 2010). All the more so for women who attempted to terminate their pregnancies themselves through the use of various poisons, herbal remedies, instruments, or by seeking the assistance of an unqualified ‘abortionist’ (Sparrow, 2010). These unqualified

abortionists, sometimes colloquially referred to as ‘backstreet abortionists’ often charged a fee for their illegal services (John, 1984). Doctors often refused to perform illegal abortions owing to the legal and medical registration implications as well as their own personal morals (John, 1984). Often, when women did experience complications, they did not visit a hospital because of the threat of imprisonment and stigma. Doctors and hospital staff also refused to accept termination patients because they did not want to run the risk of possibly spreading septicemia throughout the hospital (John, 1984; McCulloch, 2013). Between 1927 and 1935, a total of 223 women died as a result of septic termination in New Zealand (John, 1984). At this point in time, termination services were situated within a predominantly Pakeha cultural climate, where the birth of children to unwed mothers was frowned upon and men more or less controlled all of the family’s finances. This power imbalance regarding finances notably meant that women were unable to gather funds to cover the cost of a termination, unless their husband approved. In this context, the sanctity of the nuclear family was also affirmed, pregnancy terminations were criminalised and stigmatised, and effective contraception measures were decidedly lacking (Sparrow, 2010; 2014).

The Government’s response to the phenomenon of unsafe and illegal abortions was to further restrict contraception, at the same time as promoting the advantages of marriage parenthood (John, 1984). A further Governmental response was to spread the idea that pregnancy terminations constituted a “national evil” that required intensive moral education (John, 1984, p. 12). The ‘solution’ to the termination issue was believed to reside with raising the “moral and spiritual standards of the community” (Sparrow, 2014, p. 2). As might be expected, these responses did little to persuade women to avoid having a pregnancy termination.

During the early 20th Century, contraceptive methods were not discussed in public. This was to the extent where general practitioners were not taught such information at university (John, 1984). The main contraceptive practices included condoms, spermicides, douching with vinegar, withdrawing, having a hot bath and paying attention to the safe days in the menstrual cycle (Sparrow, 2010). Contraception was considered taboo and efforts were made in Parliament to

possess a register of all names and addresses of clients requesting contraception (John, 1984). Fortunately, after some deliberation this proposal was dropped. Women therefore had limited knowledge as well as limited availability of contraception and so when pregnancy eventuated, they felt compelled to resort to illegal abortions (Sparrow, 2010). This occurred in a predominately Pakeha (New Zealand European) cultural context where having an unplanned pregnancy out of wedlock was associated with societal stigma.

As noted by McCulloch (2013), there was also a relatively high incidence of suicide amongst women in New Zealand throughout the early to middle 1900s. Although the maternal mortality rate had decreased, the Perinatal and Maternal Mortality Review Committee noted that suicide remained a leading cause of New Zealand maternal mortality. This finding was supplemented with more recent figures revealing that between 2006 and 2010, 13 pregnancy related suicide deaths had occurred (Haslam & Farquhar, 2013). Because pregnancy can be a stressful time for some young women who do not have the emotional, social, or financial resources to gain access to termination, it is possible that there were more pregnancy related deaths in early pregnancy that are not accounted for (Haslam & Farquhar, 2013; John, 1984).

From the 1940s to the 1970s, Sparrow (2010) notes that women continued to seek assistance from 'backstreet abortionists' or to perform the procedure themselves. There were various myths circulating that some young women resorted to jumping up and down, falling down the stairs, and taking pessaries in order to induce miscarriages (Sparrow, 2010; 2014). Given the legal situation at that time, New Zealand qualified and registered doctors either refused to assist in pregnancy terminations or sent a referral to Australia where termination was legal (John, 1984). Consequently, termination patients were forced to 'shop around' to find a general practitioner who would be willing to provide assistance or a referral (McCulloch, 2013 Sparrow, 2010). The predicament for women was made all the more difficult owing to financial costs involved and, predictably, the number of women able to afford to travel to Australia remained very low (Sparrow, 2010).

The pervasiveness of issues concerning sanctity of life, legislation, accessibility, and safety led to the formation of various pressure groups in New Zealand during the 1970s - the Woman's National Abortion Action Campaign (WONAAC), the Abortion Law Reform Association of New Zealand (ALRANZ) and the Society for the Protection of the Unborn Child (SPUC). These pressure groups also emerged as a result of politicians' increasing concern over termination complications and maternal mortality (John, 1984). This concern was accompanied by the formation of the Auckland Medical Aid Centre in 1974 that sought to provide free, safe, and accessible local pregnancy termination service (John, 1984). This was the first practice that openly accepted and performed terminations and, not surprisingly, it attracted vigorous public debate (John, 1984). Usually protest groups coalesce in opposition to the Government's desire to maintain the status quo. However, these protest groups had such polarising opinions that a compromise was not foreseeable (John, 1984; McCulloch, 2013). As John (1984) has observed, the media's involvement caused a widespread debate and protest between pro-life and pro-choice advocates. Following the passage of the 1977 Contraception, Sterilization and Abortion Act (updating sections of the Crimes Act 1961), protestors from both sides sought the limelight with pro-life protestors continuing to protest outside hospitals (John, 1984).

The history of pregnancy termination services in New Zealand has been riddled with conflict and controversy. In contrast to the earlier experiences of women seeking terminations, nowadays young New Zealand women facing an unwanted and/or unplanned pregnancy appear to have enhanced safety and accessibility to termination services. There is very low risk of complications from terminations with between 1 and 5 per cent of women experiencing infection, scarring, hemorrhaging, and infertility (Abortion Services, 2013). Furthermore, since 1977 when pregnancy termination statistics have been available legally in New Zealand, no deaths have been linked with terminations (Abortion Services, 2013). Health professionals also report that pregnancy terminations within 20 weeks gestation statistically are safer than giving birth (Abortion Services, 2013). Terminations in New Zealand are now much safer compared with the early to middle 1900s.

However, the underlying issue of whether or not pregnancy terminations have reduced stigma and public contention is yet to be determined. The effects of this stigma are still felt many years after the 1977 legislation was enacted, as evident in Sparrow's (2014) narrative research. A common theme from these narratives post-1977 appears to be that although women now have increased accessibility, it still is not without stigma and confrontation (Sparrow, 2010). Both historically and currently, women seeking a termination sometimes are confronted with offensive images of fetuses presented by protestors (Sparrow, 2010). Furthermore, it seems that many women who have had a termination still consider how others might react to them when seeking support (Sparrow, 2014). Tentatively, this can be linked to the continued moral debate about, and controversy surrounding pregnancy terminations.

Traditional Māori views on pregnancy terminations

During pre-colonial times, there is limited and mixed evidence regarding whether Māori women were sought, or involved in, pregnancy terminations (Kent & Besley, 1990). Māori termination circumstances have been theorised in terms of prevailing economic reasons – less food for the wider *whānau* (family), personal reasons, or to eradicate illegitimate children (Hunton, 1977; Kent & Besley, 1990). However, as noted by Gluckman (1977) and several others, illegitimacy was not stigmatised in Māori society (Heuer, 1972; Patterson, 1992). Unlike Pakeha communities, Māori communities actively incorporated illegitimate children as they would with other *whānau* members (Gluckman, 1977). The evidence available suggests that generally pre-colonisation Māori pregnancy terminations were both rare and frowned upon by Māori society (Gluckman, 1972).

Best (1924) notes that in Māori communities terminations were understood to occur when a pregnant woman brought a small quantity of food to a *tapu* or prohibited place, or when she touched a person with *tapu*. This was believed to break *tapu* and would then be followed by consuming native herbs or the use of intervention devices (Best, 1924). However, the literature describing these intervention devices is both scant and inconclusive, and no Māori herbs or techniques have yet been identified.

Traditionally, in Māoridom, the fetus is perceived as having an advanced *wairua* (spirit, soul) and should the fetus experience an induced termination, then the fetus is understood to embody an evil spirit (Kent & Besley, 1990). This spirit is thought to develop as a result of the fetus not obtaining human existence, and therefore, this evil spirit may become manifested in the perpetrator or the wider *whānau* (Kent & Besley, 1990). Such revenge, known as *utu*, is believed to occur either immediately or into the future and is manifested through pain, illness, miscarriage, or the birth of a deformed child (Kent & Besley, 1990). *Atua Kahukahu* is an evil spirit from Māori mythology particular to *utu* that embodies the *wairua* of ancestors who died during childbirth (Black, 2010). *Wairua* comprises *tipuna* (ancestors) that are central to Māori life and identity (Patterson, 1992). An acknowledgment of *wairua* is consistent with Māoridom that involves *mana* (honour, prestige or influence) in one's Māori identity (Patterson, 1992). However, due to colonisation practices, the sense of *wairua* is often disregarded by society and attributions of lying and mental illness are often made (Black, 2010).

In terms of pregnancy terminations, the *wairua* of the fetus develops until 30 years of age and the spiritual cord linking them to reality is still present (Black, 2010). This spiritual cord is a metaphor for the umbilical cord whereby the cord has been cut unnaturally or prematurely. The *wairua* of this child can therefore pull on the spiritual cord and cause the woman to become depressed (Black 2010). This occurs because the fetus lets the woman know that it is still present.

Traditionally, Māori also bury the *whenua* (placenta) and fetus following birth or pregnancy termination. This burial represents the link between the present and the past, and the *whenua* simultaneously provides nourishment for the fetus, akin to the land providing nourishment for the original inhabitants of the *tangata whenua* (people of the land) (Kent & Besley, 1990). An intimate bond therefore is formed between the unborn child and the land (Black, 2010).

For Māori every life is viewed as sacred and intrinsic within their wider community. Every *tamariki* (child) is connected to their *whānau*, *hapu* and *iwi* which in turn fosters feelings of self-esteem, personal security but also

responsibility (Patterson, 1992). Through one's ancestors, behavioural notions of collective responsibility and identity were adopted and passed on to successive generations (Patterson, 1992). For Māori, child-rearing was not solely the mother's duty; rather the wider *whānau* took an active involvement (Heuer, 1972; Patterson, 1992).

Ultimately, understanding Māori perspectives regarding terminations requires acknowledgment of the diversity of Māori themselves (Le Grice, 2014). Not to do so only serves to promote the dominant culture and to inhibit accurate understandings of other cultures. As a consequence of historical and continual practices of colonisation and assimilation, Māori have had to “walk between two worlds and live a bicultural reality” (Le Grice, 2014, p. 1). This intersection of influences and values highlights the complex situation that occurs when Māori women present for pregnancy termination (Le Grice, 2014).

The research indicates that Māori women seeking pregnancy termination either have become assimilated into dominant cultural values and practices, or are provided with a choice between different cultural realities. Owing to colonisation practices whereby the biological mother predominantly cares for the infant, Māori women may feel unsupported or be socially and/or economically disadvantaged by the pregnancy news (Le Grice, 2014). As noted by Le Grice (2014), the combination of nuclear family formation and gendered division of labour led to the necessity of intimate relationship strength. This strength therefore enabled women to participate in their everyday lives (Le Grice, 2014). Some Māori women therefore sometimes seek a termination when they have concerns regarding the perceived longevity of their relationship with their partner (Le Grice, 2014). To better understand Māori representation in pregnancy terminations, it is necessary to unpack the impact of colonisation and Māori *tikanga* (right, way of doing things, custom, etiquette) on young Māori women.

Traditional Pakeha views of pregnancy terminations

As with Māori culture, there always have discrepancies within cultures regarding the place of pregnancy terminations in society. All cultures are subjected to social

constructionism wherein cultural practices change over time and represent general patterns rather than reflecting the direct experiences of everyone in that culture (Black, 1997). As noted by Evans, Rucklidge and O'Driscoll (2007), Pakeha culture is commonly viewed by Pakeha as the 'normal way'. Metge and Kinloch (1978, p.8) note that dominant cultural groups tend to take their culture for granted and therefore "do not question its general applicability". As Evans, Rucklidge and O'Driscoll (2007) observed, when discussing one's culture (simultaneously the dominant culture), individuals commonly struggle to define exactly what it looks like; in terms of associated values, practices, and ideologies (Evans, Rucklidge & O'Driscoll, 2007).

Traditionally, independence is a key component in defining what Pakeha culture looks like (Black, 2005). From a young age, many Pakeha are told that they need to be financially independent and it is relatively common, if not a 'rite of passage', that Pakeha leave home at a relatively young age (Black, 1997). This independence is also evident in the family unit when a couple marries and lives separately from their families and friends (Evans, Rucklidge & O'Driscoll, 2007). Within the household children often sleep in different rooms whereas the parents sleep in the same room because that signals that they are a 'couple' (Evans, Rucklidge & O'Driscoll, 2007). Pakeha identify their family in terms of it being their immediate or 'nuclear' family comprised of their parents and children (Evans, Rucklidge & O'Driscoll, 2007). Conversely, with more collectivist cultures, namely Māori and Pacific Island cultures, family is often broader and can include grandparents and cousins (Evans, Rucklidge & O'Driscoll, 2007). Independence can also be seen when Pakeha refer to their families as being 'there' when they need them but not 'here' in the context of everyday life (Lapsley, Nikora & Black, 2002). Pakeha therefore have to negotiate the cultural reality of being independent yet simultaneously knowing that their family will support them in times of need (Lapsley, Nikora & Black, 2002).

Pakeha values can be visualised when discussing ordered life and education. This might include a structured approach to their week where they have consistency about who is living with them, eating with them, and what activities they are likely to participate in (Black, 2002). This ordered approach can be extended to

the view of Pakeha following a 'cultural script' of finding a partner, marrying, travelling, and then having children – more or less in that order. An unplanned pregnancy however, disrupts the cultural script and might well involve consideration of termination to remedy this incompatibility.

It is important to acknowledge that this brief discussion concerning the relationship of Pakeha values to pregnancy terminations neglects, if not ignores, religious and spiritual dimensions. Whilst religion was prevalent in Pakeha culture upon settlement, New Zealand society has more recently shifted towards becoming increasingly non-secular (Snook, 1989). Statistics from 2013 indicate that four out of 10 New Zealanders identify themselves as being non-religious (Statistics New Zealand, 2013). As outlined earlier in the discussion on the historical legislation surrounding pregnancy termination, the socio-cultural context was strongly opposed to pregnancy terminations. However, following changes in family structures since the 1970s, Pakeha attitudes have generally become more accepting of women's rights over their bodies and their destinies.

Changes in familial structure and greater societal acceptance of women's rights and equality have led to a philosophical shift concerning pregnancy terminations. Following from the increased rates of divorce and increased variation in family forms, social welfare provisions soon began to reflect this shift with the introduction in 1973 of the Domestic Purposes Benefit (DPB) that provided financial assistance for solo mothers (McCulloch, 2013). At this time women's highly gendered roles were being challenged as more women began to enter the workforce (Sparrow, 2010). Simultaneously, the changing nature of relationships and family life, combined with the shift in gendered roles, meant that women with unplanned pregnancies faced a difficult dilemma. In many instances, such unplanned pregnancies were a threat to the economic viability of the family.

Unlike Pakeha society, in traditional Māori society, gendered roles tended to be complimentary. *Wahine* (women) and *tane* (men) formed a reciprocal relationship that was balanced by *whakarite* which valued balance between people in terms of the sharing of communal tasks (Herangi-Panapa, 1998). The social influence and respect for *whakapapa* (geneology) was honoured by women through their ability

to reproduce and the presence of *Te Whare Tangata* (house of procreation) (Glover, McKree & Dyall, 2008). Men were also expected to honour and protect *whakapapa* through tribal battle (Glover, McKree & Dyall, 2008). Subsequently, the assimilation process resulted in western values overriding traditional Māori values and rendering Māori norms and systems as ‘other’, lending to prejudice and discrimination (Herangi-Panapa, 1998). The power and infiltration of the assimilation process is evident in contemporary Māori society where gendered and patriarchal notions have been embedded in *tikanga* over time. *Wahine* Māori have thus had their traditional identity marginalised as a consequence of the colonising dominance of a Pakeha socio-cultural framework. As noted by Black (1997), Pakeha preoccupation with uniformity has led to detrimental consequences for Māori with the misguided assumption that all New Zealanders have equal access to resources.

Intimate relationships in the context of pregnancy terminations

Intimate relationships are vitally important when considering the context of pregnancy terminations. Terminations do not occur in a relationship vacuum; invariably others are directly involved or are affected in some way (Rue, 1994).

International evidence suggests that pregnancy terminations tend to have an adverse effect on relationships in terms of the likelihood of separation (Ring-Cassidy & Gentles, 2003). Although the extent of this adversity remains unclear, Ring-Cassidy and Gentles (2003) suggest that between 40 and 50 per cent of couples separate in the aftermath of a pregnancy termination. Other researchers have found a lower separation rate – 22 per cent in Barnett, Freudenberg and Wille’s (1992) study. The ending of a relationship has been found to be more common at both the 6-week and 1-year intervals when compared with women who carried full-term (Coleman, 2007; Lauzon, Roger, Achim, & Boyer, 2000; Robbins, 1984). Barnett et al., (1992) noted that women were responsible for initiating a relationship separation in 80 per cent of all post-termination separations. Whilst couples who experience a pregnancy termination are often at the early/non-committed stage of their relationship, the stressful incidence of a termination may strain the relationship further (Coleman, 2007). Furthermore,

many women who previously have had a pregnancy termination have found that separating from their current relationship improved their 'quality of life' (Coleman, Coyle, Shuping, & Rue, 2011).

An adverse effect of a breakdown in relationship quality has also been cited as an outcome post-pregnancy termination (Ring-Cassidy & Gentles, 2003). One study found that relationship problems were mentioned in 26.7 per cent of women in Germany who had experienced a pregnancy termination (Rue, Coleman, Rue, & Reardon, 2004). Burke and Reardon (2002) also found that 35 per cent of women who had terminated reported hatred of the man who was responsible for making them pregnant. Moreover, Sherma, Mandelman, Kerenyi and Scher (1985) found that 48 per cent of their participants reported a significantly altered relationship with their partner following the termination. The quality of the relationship has also been associated with depression rates of young women post-pregnancy termination (Teichman, Shenhar & Segal, 1993). Relationship quality may be impaired in terms of diminished mutual trust, communication, and an increase in blaming, hostility and conflict, especially if the couple had different opinions regarding the decision to terminate the pregnancy (Ring-Cassidy & Gentles, 2003). Other scenarios may include when the relationship revolves around 'disenfranchised grief' (grief that is not widely recognised in society) to the extent where other aspects of the relationship become neglected. Relationship quality can therefore be compromised if a woman feels psychological damage and/or guilt which she then attempts to place onto her partner (Ring-Cassidy & Gentles, 2003). Alternatively, she may feel guilt for going against her partner's decision and terminating the pregnancy or feel anger at her partner's coercion (Ring-Cassidy & Gentles, 2003). This guilt can be manifested in complex and interactive ways. One such way is through sexual intimacy (Ring-Cassidy & Gentles, 2003).

The research evidence regarding 'sexual dysfunction' post-pregnancy termination is equivocal. Fok, Siu and Lau (2005) have researched 'sexual dysfunction' as comprising an absence or significant reduction in sexual desire and/or the frequency of sexual acts. This study of Chinese women immediately post-termination determined that there was a significant reduction (as much as 30 per cent) in sexual desire and behaviour. Others have hypothesized this as being

attributable to possible psychological trauma and the fear of another unwanted pregnancy (Bradshaw & Slade, 2005). Tornbom and Moller (1999) also theorise that 'sexual dysfunction' is the result of the tension between sexual desire and mourning, feeling unworthy of their partner, depression, fear of falling pregnant again, and pre-occupation with their termination. Further studies have indicated that terminations precede a reduction in sexual desire and behaviour (Bianchi-Demicelli, Perrin, Ludicke, Bianchi, Chatton, & Campana, 2002; Boesen, Rorbye, Norgaard, & Nilas, 2004; Miller, 1992; Rue, Coleman, Rue & Reardon, 2004). However, one study revealed that women seeking a first trimester pregnancy termination possessed sexual dysfunction upon being made aware of their pregnancy, although this was not sustained in the two months post pregnancy termination (Bradshaw & Slade, 2005). These researchers universally conceptualised 'sexual dysfunction' as being an undesirable phenomenon, essentially implying inadequacy on the women's behalf. However, this collaboration of research did not appear to determine whether 'sexual dysfunction' was bothersome or at odds with women's desires, needs, or preferences.

It appears that there are multiple mechanisms at work. It is suggested that couples are more likely to go through separation, or have impaired relationship quality and 'sexual dysfunction', if certain variables are present (Coleman, 2007). These include: the view of terminations as the taking of a human life, pressure to terminate as a result of personal/situational constraints, the emotional connection to the fetus, negative emotions as a result of the termination, and relationship characteristics – length of time, commitment, communication, religion, and history of previous fetus loss (Coleman, 2007).

Furthermore, given the social climate surrounding terminations as being a 'private' matter, couples often carry the weight of this decision-making processes alone (Coleman, 2007). This process is further complicated due to the pressure of time to make a decision and some couples might reduce their communication in order to distance themselves from the situation (Coleman, 2007). Some women may perceive the experience of a termination as being unequal in that it is the woman who has to make the final decision. The experience of a pregnancy termination, and the decision-making that precedes it, can isolate couples and lead

to strain and conflict (Fanslow, Silva, Whitehead & Robinson, 2008).

At a national level, the literature concerning relationships post pregnancy termination is remarkably scarce. The only literature to touch on this subject is Trinh (2012) who explores decision-making in Asian women (residing in New Zealand) in relation to pregnancy terminations. When relationship problems were identified as being the reason for termination of pregnancy - specifically an unstable relationship; too soon to have a child with partner; partner's lack of support for pregnancy; abusiveness; and women's negative feeling towards their partner, were cited frequently (Trinh, 2012). Trinh (2012) also notes that the majority of her Asian participants were married and were morally opposed to pregnancy terminations. As Coleman (2007) discovered, this may place Asian women at an increased risk of relationship and psycho-emotional problems. Other than this study there is an absence of literature in New Zealand that explores the connection of intimate relationships and pregnancy terminations (Trinh, 2012).

Internationally, the connection between domestic violence and women presenting for a pregnancy termination has attracted increased interest. International research has found that there is a strong positive correlation between intimate partner violence and women presenting for pregnancy terminations (Chibber, Biggs, Roberts and Foster, 2013; Leung, Leung, Chang and Ho, 2001; Taft & Watson, 2007). Taft and Watson (2007) also discovered that women receiving later terminations were disproportionately more likely to be abused and victims of domestic violence. This finding resonates with research that indicates that later pregnancy terminations were associated with greater perceived negative interactions in their relationship and increased levels of domestic violence (Kapadia, Finer & Kalus 2011).

Relationship problems – specifically poor relationships; partner unwilling to support a baby, and negative partner characteristics are represented in up to one third of all women presenting for a termination (Chibber et al., 2013). Therefore, terminations in domestic violence relationships are often a way of getting out of the abusive relationship or to avoid bringing a child into a hostile environment (Chibber et al., 2013). In one particular study, 39.5 per cent of young women who presented for a pregnancy termination were found to have experienced domestic

violence in their current relationship (Glander & Michielutte, 1998). Women presenting for terminations also have been identified as experiencing higher domestic violence victimisation when compared with women who continued their pregnancy (Bourassa & Berube, 2007). Furthermore, these young women were less likely to tell their partner about their pregnancy and termination, and more likely to cite relationship problems as justification for the termination (Glander and Michielutte, 1998).

In New Zealand, researchers have increasingly become interested in exploring the link between domestic violence and young women presenting for a pregnancy termination. Whitehead and Fanslow (2005) report a lifetime prevalence rate of women receiving a termination of 50.8 per cent with 69 per cent of these women reporting that their current partner was violent towards them. Fanslow and Robinson (2004) have also documented domestic violence rates among these women of 33 per cent and 39 per cent respectively for Auckland and Waikato. Fanslow, Silva, Whitehead and Robinson's (2008) research revealed that women who have had a previous pregnancy termination were 2.5 times more likely to report personal experience of intimate violence. Although there is very little New Zealand based research in this area, currently there is sufficient evidence to suggest that there is a definite link between intimate violence and young women presenting for pregnancy termination.

Women who are in the midst of an abusive relationship often encounter isolation and inaccessibility to resources (Robertson, 2000). Subsequently, as a consequence of the inherent control exerted within a violent intimate relationship, women have restricted access to the outside world and therefore the 'privacy' of the home prevails (Avni, 1991). A situation that Avni (1991) likens to the institutional control that exists in psychiatric hospitals, prisons, and rest homes. This control is significant because it can impede potential interveners for example, police, nurses, and social workers from obtaining an accurate picture of the relationship (Robertson, 2000). Furthermore, attempts at leaving a violent partner are highly risky and can include possibilities of being stalked, threatened, and/or even murdered (Jordan, 2004). It is also noteworthy that many abusive partners are in control of household finances and there may also be children involved, making the decision to leave more complicated (Robertson, 2000). Victim-

blaming can be quite common when women re-connect with their abuser. However, because the level of protection and security of safety provided in the community is often insufficient (Robertson, 2000), it sometimes can be more practical, logical and to an extent, safer to stay with a partner than to leave (Jordan, 2004).

Research regarding whether terminations lead to long-lasting effects on future relationships is mixed. Moreover, the link between the effects of a termination on relationships is highly dependent upon the unique experience of the participant (Coleman, 2007). It therefore is too simplistic to assume that terminations lead to adverse relationships without considering all other factors that might potentially create a susceptibility to increased difficulty post-termination. An unwanted pregnancy is often associated with sexual problems, dysfunction, and relationship conflict (Bradshaw & Slade, 2005). However, this is often confined to the discovery of pregnancy itself and does not affect future relationships. The nature and quality of the relationship pre-pregnancy has been found to be a significant contributor towards post-pregnancy termination adjustment (Reis & Sprecher, 2009).

Reis and Sprecher's (2009) study of women who had pregnancy terminations compared with women who had not had an unwanted pregnancy found that one year post-termination both groups were in stable relationships of roughly similar durations (Reis & Sprecher, 2009). However, Coleman, Rue and Coyle (2009) noted an increase (between 116 and 196 per cent) in arguments about children, arguments about money (75 per cent), conflict with partner's relatives (80 per cent), and sexual dysfunction (between 122 and 182 per cent). Furthermore, there appeared to be a greater chance of relationship problems if one partner felt unsupported in their decision to have a termination (Reis & Sprecher, 2009). Resentment therefore can arise when there are conflicting views over the decision of whether to terminate or not (Reis & Sprecher, 2009). This resentment can lead to increased animosity and either the continuation of an unhealthy relationship or its abrupt dissolution (Bradshaw & Slade, 2005). Ultimately, it appears that there are complex variables that influence whether pregnancy terminations have an impact upon current or future relationships and therefore more research in this area is needed.

Quality of care in a pregnancy termination setting

Quality of care in this scenario refers to the institutional health care systems that young women have chosen to access. Care in this case refers to care provided by health professionals in the journey towards a pregnancy termination. This journey involves a number of steps and stages: the first visit to a nurse or a doctor to confirm pregnancy; the first visit to the doctor in order to discuss pregnancy options and undertake medical tests; experiences during ultrasound; experiences with social workers pre-termination; experiences with pre-counselling; the termination setting itself; and the procedure and after-care. In the pregnancy termination context there are two elements of care; access and effectiveness – each of which simultaneously include technical/clinical, cultural, and interpersonal aspects (Campbell, Roland & Buetow, 2000). Therefore, important questions concerning quality of care arise: Can young women get access to care when they need it? Is this care effective in terms of interpersonal relationships and technical effectiveness? How does quality of care impact on women's overall experience of a termination? How important are interpersonal qualities by health professionals in the journey to receive a termination? (Campbell, Roland & Buetow, 2000). These are some of the questions I intend to explore through this research study.

Accessibility as an aspect of quality of care is commonly understood to involve an absence of geographical barriers (Campbell, Roland & Buetow, 2000). This can be understood in terms of geographical location (or isolation) from available facilities as well as the use of, and access to, premises for individuals with disabilities. It therefore becomes the responsibility of institutional health care systems and professionals to ensure that structures and services are available that can accommodate the needs of individual clients (Campbell, Roland & Buetow, 2000). Typically this involves access to a female nurse/general practitioner, and/or access to a specialist service (private pregnancy termination service) or other form of health professional by referral (counsellor). Other important components of access include affordability as well as the length/availability between appointments (Campbell, Roland & Buetow, 2000; Silva & McNeill, 2011). Affordability also encompasses transport costs, prescription costs, as well as any childcare needed, or time off work that is required.

Snook and Silva (2013) noted the importance of geographical services when undertaking research into the safety and effectiveness of local termination providers. They found that local services led not only to a reduced waiting time but also to cost-savings for an economically deprived and vulnerable population in Gisborne (Snook & Silva, 2013). This population has been identified in the Census as having the highest levels of economic deprivation when compared with other regions in New Zealand (Atkinson, Salmond, & Crampton, 2014). This is an important consideration, especially when referral to an external provider often involves finding the use of a vehicle, money for fuel, accommodation costs, and the like. The availability of local pregnancy termination services therefore offers greater accessibility for clients.

Accessibility, in terms of the absence of barriers, can also involve minimising harassment (Henshaw, 1995). For example, women considering a pregnancy termination are often faced with the prospect of harassment by pro-life protestors (Henshaw, 1995). Henshaw (1995) observed that these forms of harassment included picketing, blocking access, taking details of vehicle's number plates, vandalism, threats against the person, and stalking. Henshaw (1995) further noted that the likelihood of harassment to termination receivers increases with the increased caseload of practitioners. Public health care facilities are likely targets of protest due to this increased demand for the service. Whilst these public protests have lessened somewhat in New Zealand it nevertheless can significantly affect woman's decision-making or contribute additional unwanted stress on those seeking terminations (Henshaw, 1995).

The ability of doctors who personally oppose pregnancy terminations to refer a patient to another provider is another factor in accessibility to termination services. As argued by Women's Health Action (2014), the Code of Health and Disability Services Consumer Rights guarantees that each and every patient is entitled to have all options explained to them. Furthermore Code six of the Health and Disability Services Consumer Rights states that patients must also be given the option of being able to seek a different opinion from another provider (Women's Health Action, 2014). Currently doctors do not have a legal obligation to refer to another termination provider when this contradicts their personal

beliefs (Women's Health Action, 2014). Because General Practitioners are the 'gatekeepers' for women considering a termination, women may not receive valuable information about their options (Women's Healthy Action, 2014). Furthermore, as Silva, McNeill & Ashton (2011) have found, those who receive a termination earlier in their pregnancy tend to have reduced rates of complications when compared with women whose pregnancies exceed 10 weeks (Silva, McNeill & Ashton, 2011). If there are delays due to accessibility to services on the grounds of doctor's personal beliefs, this knowingly places women at an increased risk of physical complications (Women's Health Action, 2014).

Effectiveness, as a further component of the quality of care, is at least based partially on evidence and knowledge of the condition, procedure, and possible complications (Campbell, Roland & Buetow, 2000). However, the link between process and outcome, for example, that a Dilation and Curettage (D&C) procedure for a termination is one of the most widely used and effective, needs to acknowledge women's individual circumstances, their beliefs, religion, and culture (Campbell, Roland & Buetow, 2000). Negotiation and continual communication needs to occur between doctor and patient to ensure the provision of genuine patient-centered care (Campbell, Roland & Buetow, 2000). This negotiation needs to take account of the unique ways that the patient understands and identifies with the termination experience; as well as choice of methods and informed consent. Choice of methods, that is, knowledge of suitable procedures for the patient, the ability to choose a method with reassurance and incorporating the patient's perspective on the final decision and informed choice - the provision of accurate knowledge to the patient so they feel empowered to make the best decision for them given their unique circumstances are important components of quality of care (Donabedian, 1988)

Quality of care also encompasses continuity mechanisms and post-termination follow-up care (Campbell, Roland & Buetow, 2000). This is particularly important for pregnancy terminations whereby a follow-up ensures there are no medical or psychological complications. Follow up care will most likely need to be coordinated amongst different health providers where referrals to counsellors, gynecologists, or social welfare staff might be warranted. Post-termination follow

up and effective pre-termination counselling is imperative because inadequate counseling at either point is known to be associated with increased relationship problems and sexual dysfunction (Coyle, Coleman & Rue, 2010). Even the perception of sub-standard counselling throughout the termination process can lead later to psychosocial stress and interpersonal difficulties (Coyle, Coleman & Rue, 2010). Follow-ups from health professionals to clients is also a significant component of quality of care because it verifies whether the woman was able to receive the care she required or whether there was a gap in the health system (Simmonds & Likis, 2011). Simmonds and Likis (2011) concluded that the quality of the referral process for care co-ordination and continuity can increase patient satisfaction significantly (Simmonds & Likis, 2011).

Effectiveness also involves the co-ordination of different but nevertheless necessary services for young women, like counselling services and social welfare. Effectiveness regarding technical competency refers to the competence of the clinicians, the clinical technique adopted, compliance with protocols, and the meticulous application of clinical methods (Campbell, Roland & Buetow, 2000). The privacy, convenience, quietness, and cleanliness of the health care providers' facilities are extremely important (Donabedian, 1988). David, Reichnenbach, Savelieva, Vartapetora and Potemkina (2007) extend the idea of quality of care to argue that pregnancy termination settings may need to endorse client-centered care more so than any other setting owing to the sensitive and complex nature of the psychological and physical care needed (David, Reichnenbach, Savelieva, Vartapetora & Potemkina, 2007).

Identification, referrals, and safety plans for women who are in an abusive domestic relationship are crucial. Robertson (2000) notes that active linkages need to be formed collaboratively with other justice and social service agencies to ensure patient safety and well-being. There also needs to be effective screening for domestic violence which might be a designated task for the pre-termination counselor, in order to comprehensively identify risks for abused women and to develop a collaborative risk management plan (Fanslow, Norton & Robinson, 1999). Significantly, a supportive counselling environment in a termination

setting has been shown to be a critical component for women's safety and wellbeing.

Interpersonal relations between provider and patient, and within providers, comprise a further component of quality of care. Interpersonal relations between patient and health professionals must rely on understanding, respect, honesty, sensitivity, two-way communication, and the provision of a flexible and welcoming environment that encourages question-asking (Bruce, 1990; Donabedian, 1988). Other important aspects of interpersonal relations noted in the research literature include confidentiality, informed choice, reminder of alternative choices, empathy, tact, and also utilising the 'art of medicine' to tailor individualised interpersonal interactions (Donabedian, 1988, p. 1744). Interpersonal relations within providers also have important ramifications for the quality of care. These include the programme's ideology, resource allocation, staff to patient ratio, and managerial style (Donabedian, 1988). The staff to patient ratio and resource allocation can place an added burden on staff who have to work increased hours or at an increased pace to meet demand (Donabedian, 1988). This resultant stress can lead to fatigue or burnout and can potentially result in mistakes being made in the workplace. Generally, unlike technical competence, patients can readily identify interpersonal relations and evaluate their quality when undergoing a medical procedure (Bruce, 1990). Engaging in appropriate 'small talk' that avoids any political or controversial news issues is seen as one way of gaining a patient's trust and facilitating care (Lecca, Quervalu, Nunes, & Gonzales, 1998).

Research investigating the quality of care during and post-termination has generally demonstrated positive results. Research into Canada's quality of care by Guilbert and Roter (1997) found that satisfaction levels with the induced termination experience were high. These satisfaction levels also were strongly related to the clinician's technical ability with an absence of complications perceived as being evidence of high quality care (Guilbert & Roter, 1997). Support from the nurses and doctors also was noted as being of a high quality (Guilbert & Roter, 1997). While participants also rated their preparation, based on knowledge derived from health professionals as high, (Guilbert & Roter, 1997),

those participants who came alone, as opposed to those who bought a support person, had negative experiences of quality of care (Guilbert & Roter, 1997). Because participants who came alone felt less prepared and more vulnerable, health professionals were urged to tailor their interventions for those women who arrived at the clinic alone (Guilbert & Roter, 1997).

Research in Finland also identified high overall satisfaction with the termination procedure (Sihvo, Himmenki, Kosunen & Kopenon, 1998). However, 25 per cent of these participants reported wanting more discussion with a health professional before the procedure and 30 per cent preferred a discussion with the physician/nurse immediately afterwards (Sihvo, Himmenki, Kosunen & Kopenon, 1998). This may indicate that health professionals in the termination setting should be mindful of those patients who arrive alone and try to ensure that they feel comfortable and supported.

Quality of care is an important concept when young women seek and receive a pregnancy termination in New Zealand. Although pregnancy terminations up until 20 weeks gestation are legal in New Zealand, stigma and sometimes secrecy surrounding the pregnancy still remains and women rely heavily on health professionals' guidance. New Zealand researchers investigating such quality of care have discovered that on average, women have to travel a distance of 442 kilometres (there and back) to receive a pregnancy termination (Silva & McNeill, 2008). Furthermore, three of the five regions that do not have termination clinics have a higher than average Māori population (Silva & McNeill, 2008). This presents an unnecessary burden on an already disadvantaged population some of whom are simultaneously undergoing a stressful event. Silva and McNeill (2008) conclude that for one-sixth of all New Zealanders, not only are termination clinics difficult to reach geographically but there are additional costs to be considered in terms of transport costs, hospital parking charges, access to vehicle/means of transport, childcare costs, accommodation costs, and time off work. In order for equity to be achieved, Silva and McNeill (2008) concluded that surgical and medical termination services should be spread to rural areas. At the very least, women should have their termination associated costs paid for to ensure equal accessibility. Jewell and Brown (2000) note a differential effect of

travel costs on younger women because these women tend to be comparatively economically disadvantaged and possibly have reduced access to social support (Jewell & Brown, 2000). They further found that in rural areas where termination service access was restricted or absent, there tended to be fewer pregnancy terminations performed in that area. As part of New Zealand's commitment to reducing inequalities in health provision more attention needs to be given to the issue of accessibility (Pearce, Dorling, Wheeler, Barnett & Rigby, 2006).

Research by Silva and McNeill (2011) has shown that New Zealand first trimester termination patients endure significant delays in accessing termination services with women who presented to a termination clinic earlier in their pregnancy encountering the most significant delay, even taking account of delays in decision-making (Silva & McNeill, 2011). The greatest delay was from the time of the first appointment with a general practitioner to the final termination procedure (Silva & McNeill, 2011). Moreover, women who desired and/or needed a second appointment with their referring practitioner experienced an even greater delay in access to a termination compared with women who had a single visit (Silva & McNeill, 2011). Furthermore, women who received a termination from a private provider experienced 12 fewer days (on average) in the termination health care system compared with women who received a termination in a public service (Silva & McNeill, 2011). Early pregnancy termination is widely argued to be desirable because clinical and psychological complications can occur for women with longer gestations (Silva & McNeill, 2011). It appears that the public termination system is under considerable pressure and that more co-ordination, and perhaps co-operation, between the public and private providers is needed to streamline the pregnancy termination process.

Quality of care also involves cultural competency and safety within the pregnancy termination setting. Papps and Ramsden (1996) regard cultural safety in New Zealand nursing as placing "an obligation on the nurse to provide care within the framework of recognizing and respecting the individual" (p. 494). When a health professional and patient meet, they carry with them their own colonial histories and material disadvantages that might well challenge different statuses and power relationships (Papps & Ramsden, 1996). Cultural safety therefore seeks to address

imbalances in power between patients and health professionals. Cultural competency welcomes, in fact embraces, knowledge about not only culture and ethnic diversity but also difference more generally, for example, age, gender, disability, religious or spiritual beliefs, socioeconomic status and sexual orientation (Papps & Ramsden, 1996). This has ramifications for the way that health professionals approach health care for pregnancy termination patients, specifically owing to New Zealand's multiculturalism and the (perhaps different) moral decisions regarding unwanted pregnancy (Papps & Ramsden, 1996). With respect to pregnancy terminations, the cultural competency component requires more psychological and socio-cultural attention because both are dependent on, and specific to, the individual and the medical aspects of the procedure (Shing-Tseng & Streltzer, 2008). For example, in the case of an acute appendicitis, the focus is predominately medical with very little attention needing to be given to associated factors. In contrast, areas in health care professions that might be relevant particularly for pregnancy terminations include different cultural ways of understanding birth, death, pain management, and illness – in this instance illness may involve infection or hemorrhaging (Shing-Tseng & Streltzer, 2008). Overall, differences in power, status, and medical knowledge collectively can result in harm for women requesting a termination, unless there are adequate cultural safety support mechanisms in place.

It is important to acknowledge that cultural competency is an ongoing and evolving process. At a surface level it involves recognising the unique and often vulnerable status of disadvantaged groups (Simmonds & Likis, 2011). Looked at more closely, it also involves being aware of practices and belief systems in other cultures that might lead women to perform self-terminations owing to a fear of disclosure to health professionals (Simmonds & Likis, 2011). Disclosing the results of pregnancy testing to young women also requires careful consideration regarding the use of neutral language such as “the test is positive which means you are pregnant (Simmonds & Likis, 2011, p. 798). This avoids leading statements such as “Congratulations!” or “you must be so happy” (Simmonds & Likis, 2011, p. 799). An examination of one's own biases and belief systems, and the knowledge of how to utilise this in practice, provides a foundation for quality care. Alternatively, asking how the woman feels about the termination can

provide an opportunity to refer her to an appropriate counselling service (Surman, 2001).

A nurse or general practitioner's intuition about vulnerabilities may serve to guide whether they become an active or passive member of care co-ordination (Surman, 2001). Alternatively, for some individualist cultures, acknowledging independence and autonomy by giving the young woman knowledge about a referral thereby placing the responsibility of acting on that woman, can be an example of cultural competency. The health professional can then inform the patient of the particular services that various clinics offer, discuss the cost, waiting times, availability of language translators, and the likelihood of any anti-termination protestors (Simmonds & Likis, 2011). In this case, the professional is providing valuable information that allows the woman autonomy in making her own decision. Of course individual circumstances, belief systems, and experiences are vital components in the provision and extent of care co-ordination. Pregnancy testing can provide an opportunity where education and care co-ordination can form coalesce (Surman, 2001).

Cultural sensitivity is particularly important for Māori women who are engaged in the process of deciding upon a pregnancy termination. Upholding the Te Tiriti o Waitangi principles of protection, partnership, and participation are crucial in ensuring that these young women leave the service feeling empowered, respected, and with their holistic well-being intact. However, as noted by Le Grice (2014), Māori participation in a pregnancy termination is a complex phenomenon because there are tensions between the cultural values of Māoridom and Western notions of individualism, colonisation, assimilation, and the existence of various social and economic structures (Le Grice, 2014). It therefore is imperative that health professionals working in this sector have competence in upholding *tikanga* Māori and respecting associated Māori concepts of *whānau* and *wairua* (Le Grice, 2014). Notably, when observing ambivalence in termination settings, it is crucial that there are professionals who are both competent and compassionate when working with Māori youth. This requires local community knowledge and the availability of networks that can provide young New Zealand women with safe contacts who can help to mediate internal conflicts.

In exploring the notion of quality of care, Campinha-Bacote's (2002) 'Process of Cultural Competence in the Delivery of Healthcare Services' Model proves useful. This model uses the metaphor of a volcano to illustrate how *culture desire* leads to *cultural competence* which, in turn, encompasses awareness, skill, knowledge, and cultural and social encounters (Campinha-Bacote, 2002). At its very basic level cultural desire includes the concept of care that is derived from internal aspiration rather than external pressure (Campinha-Bacote, 2002). Strategies that may assist in cultural desire involve appreciating that every patient is a unique individual with the right to safe and appropriate care. *Cultural awareness* involves being aware of one's own cultural beliefs, values, and practices and how these might affect work and patients, whereas *Cultural knowledge* entails searching and obtaining education about diverse cultures and ethnicities (Campinha-Bacote, 2002). Possessing knowledge about cultural worldviews therefore assists professionals in understanding how this guides cognition, behaviour, and how to use this in their practice (Campinha-Bacote, 2002). *Cultural skill* refers to the collection of culturally relevant information concerning the present issue and conducting a culturally based and appropriate physical assessment (Campinha-Bacote, 2002). Accordingly, cultural skill encompasses both the cultural assessment tool used and the extent to which this tool is accompanied by cultural sensitivity. However, due to a myriad of factors, health professionals invariably supplement this prior cultural knowledge with knowledge of individual factors of their patients (Evans, Rucklidge & O'Driscoll, 2007). *Cultural encounters* also refer to interaction with others from diverse groups in order to prevent stereotyping and reinforce existing beliefs (Campinha-Bacote, 2002). Cultural encounters incorporate the use of formally trained translators rather than relying on family members, this might cause misunderstandings because family might not be familiar with the medical terminology (Campinha-Bacote, 2002). Overall, this model of cultural competency helps to guide health care professionals as to the appropriate quality of care.

Chapter summary

This chapter has provided a historical context for pregnancy terminations, providing detailed information about cultural perspectives. This is significant as

New Zealand is a multi-cultural nation that has a moral and legal obligation to Māori as the indigenous population. Differing historical cultural perspectives concerning terminations can provide greater opportunities for cultural competency in the New Zealand termination service. As part of a narrative framework, the investigation of culture and terminations further provides richer and clearer understandings. A survey of the academic literature reveals gaps, inconsistencies, and the development of theories, leading to the necessity of this research in filling this void, and challenging various international-based theories.

Research objectives

The purpose of this research is to investigate the experiences of young New Zealand women who have had a pregnancy termination. Consistent with the definition of the United Nations, ‘young’ was defined as being aged 25 years or younger at the time of the termination (United Nations Department of Economic and Social Affairs, 2008). For this research, a particular emphasis was placed on the bi-directional role of intimate relationships in the decision-making process and life following the pregnancy termination. Moreover, the ‘quality of care’ received by women who have had pregnancy termination was explored. This research focuses on the unique experiences and interactions that these young women have encountered throughout their personal journey.

The following four research questions have guided my research:

1. How has a pregnancy termination affected present and future intimate relationships (if at all)?
2. How has an intimate relationship affected the overall experience of a pregnancy termination, with specific reference to decision-making, post-termination coping and life after termination?
3. What ‘quality of care’ experiences have these young women received – interpersonally, clinically, and in terms of geographical and financial accessibility in relation to their pregnancy terminations?
4. How does ‘quality of care’ and intimate relationships influence and shape young women’s overall experience of a pregnancy termination in New Zealand?

Chapter Three: Method

This section outlines the methodology adopted for this investigation into pregnancy termination experiences for young New Zealand women. Included within this section is a detailed explanation of the approach used in this study, descriptions of the participants and the recruitment process that was undertaken, the interview schedule, ethical considerations, and the interview procedure utilised throughout this research. The thematic approach to data analysis is also explained within this chapter, along with the rationale for choosing this method of analysis.

Narrative approach

For the purposes of this research, a narrative approach has been adopted to frame and conceptualise the perspectives of young New Zealand women who were interviewed about their pregnancy terminations. Notably a narrative usually refers to a short story about a particular event with particular characters or an extended story about a feature of one's life (such as work, marriage, illness or trauma), or a life history narrative encompassing the progression from one's birth to the present time (Chase, 2008). Narratives therefore are verbal action observations that explain, entertain, defend, or challenge contemporary or socio-historical events, conditions or contexts (Gamson, 2002).

A narrative approach is a process of making meaning from retrospective events in that it involves the shaping of past experiences (Chase, 2008). Narrative approaches involve understanding the action of the self and others in an attempt to provide a meaningful construct and context (Gamson, 2002). Actions and events also are connected in a manner that encourages tracing and analysing the outcomes of these over time (Chase, 2008). Narrative researchers also acknowledge the social resources and circumstances that might empower or constrain individuals, and the effect that this has on one's own narrative (Holstein & Gubrium, 2000). Individuals are thus only able to construct narratives and perceptions of their context in ways that are comprehensible to their local community and culture (Holstein & Gubrium, 2000).

Borg (2001) notes that narrative approaches deserve more credibility on the grounds that they effectively enhance the participant's self-awareness and aid in future decision-making by providing a highly personal and educational experience (Borg, 2001). Furthermore, the insights produced by the participants and researchers have the potential to create significant meaning for those reading the narratives (Borg, 2001). As argued by Crossley (2000), and illustrated in this thesis, narratives can also reveal cultural and social discourses that can either be empowering or detrimental – either way, they provide opportunities for discussion by participants, the researcher, and the readers. Crossley (2000) further notes that narratives can reveal the relationship between the self and social structures by simultaneously highlighting the complexity of individual life and the creation of personal identity.

This study of young women's experiences of a pregnancy termination involves speaking, reading, and writing as ways to converse with and engage participants in self-reflection. For some participants, this might be their first opportunity to talk to a third person about their experiences and a narrative approach has been shown to put participants at ease because the nature of the process is transparent, constructive and relatively 'hands-on' (Borg, 2001). Narrative processes of engagement are seen as being particularly attractive for those individuals willing to share their experiences owing to the focus on the interviewee and the opportunity to share personal feelings rather than 'facts' (Hiller & DiLuzio, 2004). They may also serve to validate participants' experiences and to signal that their stories are worthy of attention (Hiller & DiLuzio, 2004). Furthermore, the knowledge that there are other participants with similar experiences can reduce one's feeling of isolation and indifference (Hiller & DiLuzio, 2004). This is particularly relevant for young women who have previously terminated pregnancies as they remain a marginalised group in New Zealand society.

Participants

Six participants whose experiences were wide ranging were interviewed for this research. As with any qualitative research, I envisioned that the participants would reflect a variety of experiences with which readers could make some connections. Participants were selected strictly on a first in, first serve basis. This minimised

the potential for researcher bias regarding what narratives might be particularly relevant to the research questions (George & Bennett, 2004). Additionally, in order to counter this criticism, the researcher ensured that their own position is made clear before undertaking their research (MacPherson, Brooker & Ainsworth, 2000). This goal is achieved by having informed women in this study of the researcher's motivations (see Appendix D for this study's letter of invitation and information sheet).

Participants from both Manawatu and Waikato regions were interviewed with a 50:50 split of participants between these two locations. The reason for the deliberate inclusion of participants from different geographical areas was to allow for the possibility of different quality of care experiences in terms of the way the service was delivered, waiting times, and available termination methods.

Participants also ranged in age from their early twenties to early forties. Two participants identified as New Zealand Māori, one as New Zealand Māori/Samoan whilst the remaining three identified themselves as being New Zealand/European. The various ethnicities of participants in this study allows possible important cultural factors and dynamics in the realm of pregnancy termination to be explored. Moreover, all participants were either working full-time or studying, with some undertaking both - two were in full-time employment, two were working part-time whilst studying whilst the remaining two were full-time mothers.

In terms of previous children, two participants already had children prior to their termination and one participant had a child following her termination. Four of the participants had not had any children before or after the termination. The experiences of having previous children, or not, can therefore be examined within a narrative construction framework that explores the relationship (if any) between the experience of termination and the desire to have children. The terminations were performed over a 17 year period (1997 to 2014) which offers additional insight into the participants' socio-cultural and historical experiences and contexts. Moreover, because five of the participants had since gone on to have a

relationship following their terminations, the effect of a previous termination on these subsequent relationships can also be explored.

The criteria for inclusion in this research were twofold - that participants had to be aged 25 years or younger at the time of termination, and their pregnancy had to be medically confirmed by way of a positive pregnancy or blood test. This excluded any terminations that resulted from the use of the Morning After Pill. This decision was taken because simply taking the Morning After Pill is no confirmation that a pregnancy actually existed because the medication is taken too soon after perceived conception.

The recruitment process

Recruitment posters were placed in sexual health clinics, pregnancy centres, and youth clinics in both Hamilton and Palmerston North. This was intended to attract a larger pool of participants that would allow experiences in different geographical regions to be investigated. Moreover, A4 size recruitment posters were placed in the counselling and student health areas at the University of Waikato and Wintec campuses. Potential participants were invited to contact the researcher through email (as advertised on the recruitment poster) to express their interest in participating in the study. Those who responded were provided with an information sheet that was emailed to each participant (Appendix D) along with with attachments containing the consent form, which contained full contact details, and outlined participant's rights.

Additionally, some participants who were unable to participate in 2014 in my Honours Dissertation research (owing to the high response rate I had and the need for a limited sample size) contacted me and recommended others who potentially could participate in this research. Subsequently, some participants for this study were recruited as a result of 'snowball sampling'.

Once all six participants completed the interviews, the researcher then contacted organisations that displayed recruitment posters. It was agreed that recruitment posters would be taken down in order to avoid disappointment from missing out in this research.

Interview schedule

Consistent with a narrative approach, participants were encouraged to relive their experiences in a way that was most appropriate and comfortable for them. This included the researcher inviting the participant to start in the narrative wherever they felt most comfortable. For most participants this was a chronological version where background factors and their upbringing were first identified. Contextual factors that were occurring in the lead up to the discovery of pregnancy also were drawn on - for example, education, flatting, friendships, travel, etc. The themes covered included: life before falling pregnant, discovering pregnancy, factors that led to a termination, past and current intimate relationship, culture and religion, quality of care, relationship after termination, and advice for women who are considering a pregnancy termination.

The 'life before falling pregnant' initial theme sought to build the narrative of each participant and contextualised her termination decision. The 'discovery of pregnancy' theme included emotions, fears, and the action taken when the participant discovered her pregnancy. The 'past and current intimate relationship' theme discussed the quality and nature of previous relationships prior to the pregnancy. Within this theme the relationship in which the pregnancy occurred and relationships post-termination also were explored. The 'culture and religion' theme covered the familial, spiritual and cultural identification and background of the participant respectively. The 'quality of care' theme covered the quality of clinical and interpersonal care the participant received from their termination service. The 'relationship after termination' and 'advice for women considering a termination' refer to the quality and nature of current relationships, insights and advice for women in a similar scenario respectively.

Generally, these themes progressed in a relatively logical manner allowing the participant the opportunity to share their story with minimal guidance and interruption from the researcher. For some participants, they spoke of additional events that occurred outside of these semi-structured themes, for example: 'post-termination counselling' and 'first encounter with terminations'. These themes were included as 'extras' in their case studies as they were fundamental to their

respective narratives. Moreover, in one instance the ‘intimate relationship education’ theme was not included for a participant’s narrative as she did experience this during her schooling.

Ethical considerations

Ethical approval was attained from the University of Waikato’s Psychology Research and Ethics Committee. The subsequent approval letter was also sent to participants who expressed interest in participating. This was to ensure transparency in the research process and to ultimately provide written verification of the ethical status and credibility of this research project. Participants were also provided with information explaining their right to withdraw from the research and this was explained clearly and was also reiterated prior to the initial interview. Also, throughout the recruitment and interview process, many opportunities were provided for any questions concerning the research and/or ethics. Anonymity and confidentiality were explained carefully to the participants and these were protected at all times. The participants’ email addresses were available only to the researcher and emails were used to send interview summary reports. It is important to add that at no stage did the researcher intentionally utilise their position of power or authority over the participants.

At the outset, I was aware of the possibility of emotional distress for participants when discussing their experiences of pregnancy terminations. Before the interview was recorded I reminded participants that they could have a break during the interview if they found the content becoming upsetting or unsettling for them. I also reaffirmed to all participants that they did not have to reveal any information if it made them feel in anyway uncomfortable. During the interviews, most participants were able to discuss their experiences freely and with minimal distress. Whilst the researcher cannot confirm factually what experiences participants had outside of the interview, many commented on how the interview process felt ‘therapeutic’ for them. For some, this was because they had not confided to an unrelated third person since their termination. Narrating a significant life event or a story of repression, poverty, or survival, has been shown to facilitate positive change for the narrator (Langellier & Peterson, 2011). In this instance, it can lead towards emancipation or re-worked versions and

understandings of life struggles (Langellier & Peterson, 2001). Alternatively, for others, narration leads to the need to express and share one's life experiences (Chase, 2008). By distancing or removing oneself from a dominant and unproductive narrative, one can become transformed positively (Crossley, 2010). Alternatively becoming more aware of the self, narrative approaches can assist both the participant and the researcher in richer insights, often at both the micro and macro levels (Borg, 2001). A narrative approach therefore provided participants with a platform to retell their story in a safe, transformative, and empowering way.

The day after each interview, I emailed each participant to see how they were feeling and to check whether any additional support was needed. Most participants responded within a week and indicated that they were very keen to persist with the research. There was one exception, after the first interview, where a participant had to withdraw herself from further interviews owing to the ill-health of her partner. Given the qualitative and face-to-face nature of this research, it was imperative that the researcher was prepared for participants to be uneasy or to feel upset because of the very real possibility that participants might be re-traumatised as a result of re-visiting challenging emotionally-laden memories (Le Grice, 2014). It therefore was crucial that the interviewer was prepared for this possibility and felt competent in alleviating any discomfort or distress. The researcher also had to be prepared for participants who found the experience to be relatively mundane and no longer a significant feature of their life story.

Interview procedure and process

Prior to the first interview the researcher revealed that the interviews would be of a relatively informal semi-structured nature. This involved preparing a range of different topics or themes ahead of time for participants to respond to. This was provided to all participants in this research. Semi-structured interviews provide some structure to the interview but also allow different trajectories to be pursued. The open-ended and broad definition of topics, rather than specific questions, allowed new understandings about the research topic to be formulated (Boyatzis, 1998). The broad topic areas have provided some degree of uniformity or

standardization for at least some of the information being sought which helps to increase reliability (Clarke & Braun, 2013).

The interview began with the researcher explaining the reason for the interest in this area of research and the participant was then invited to share their story with minimal direction and input from the interviewer (Hiller and DiLuzio, 2004). In doing so, the participant experiences a sense of control and empowerment in telling their story (Hiller and DiLuzio, 2004). The researcher guided the participant when necessary but often took 'a back seat approach' to interviewing thereby allowing insights to be gleaned because the participant was free from constraints (Borg, 2001). A semi-structured interview was used as a suitable method of data-gathering, particularly as a (potentially) sensitive issue was discussed that the participants have not discussed or thought about for some time (Hiller & DiLuzio, 2004). A further strength of semi-structured interviews is that they can gently guide participants in a way that facilitates recalled memories, this was especially useful as for some participants their termination experience occurred a number of years ago. The flow and sharing of ideas and events offered through a semi-structured interview is also more natural because the questions are 'open' rather than 'fixed' (Boyatzis, 1998). Such a bidirectional process can include questions directed to the researcher and can assist in the co-construction of the narrative. Semi-structured interviews can therefore be beneficial for topics that are rarely talked about, and help to strengthen rapport and trust within the research relationship.

The participant was informed of the narrative methodology underpinning this study, and what this meant for their freedom in narrating their story. As a narrative approach also explicitly views truth and knowledge as being created by personal experience, reflection, and story-telling, (Bishop, 2006; Schwandt, 2006), the researcher emphasised the nature of the participant's story as being 'reality'. Reality is therefore derived from how people perceive their life and by unveiling one's story enabling the subsequent interpretations, actions, and behaviours to be examined more closely (Bishop, 2006; Schwandt, 2006). Narrative analysis also acknowledges the contextual, transformational, and co-constructed nature of participants' stories. Therefore it was briefly outlined to

participants how the act of recalling a particular memory is understood to be dependent entirely on reconstructions (Bishop, 2006). These reconstructions often will change with time owing to different experiences, discoveries, social contexts, and identities (Bishop, 2006). The researcher was therefore able to inform participants of the possibility for narrative and self transformation due to richer insights into one's own life and circumstances

The researcher included the consent form, list of regional counselling services, and a list of the interview themes. By giving potential participants the forms so early in the recruitment process, participants had sufficient time to consider their participation. Furthermore, these forms ensured transparency and allowed participants to ask questions without the pressure of time or face-to-face interaction. The researcher informed each participant in this first interaction that they would be contacted one week later.

At the beginning of the initial interview, participants were reminded of their rights. This included the right to withdraw within one week following the date of the first interview. Furthermore, there were many opportunities available for questions prior to each interview. The participants who agreed to participate in the research form signed the consent form and agreed to be audio recorded during the interview. The participants understood that three interviews were to take place (approximately one hour for each interview). Participants were also informed that the thematic areas would be spread out evenly across these interviews unless otherwise specified by the participant. The first few minutes of the first interviews offered participants the opportunity to decide how they wanted to approach their story-telling in a way that was most suitable for them.

The participants were interviewed by the researcher on a one-to-one basis and face-to-face. A suitable time and venue was negotiated between the researcher and participant. This venue chosen was either at a quiet café, park, or a small room that could be booked at a local library. The participants were advised that they could have a support person/whānau present at the interview. Despite this, no participants chose to be accompanied by a support person in the interviews.

The interview was conducted over tea/coffee with food provided when the interactions occurred outside of a café environment. Participants appeared to enjoy having this component to the interview and it seemed to make the interview less formal and intimidating. Occasionally, this food/drink was a good distraction if participants needed to pause to reflect. Furthermore, when it seemed as though the participant was struggling with memory recall, the researcher allowed the participant sufficient time, without making the participant feel uncomfortable. It was then suggested to the participant that she could think about this memory while the interview progressed. Often this was an opportunity to share a laugh about having ‘memory lapses’ and therefore made the interviews more relaxed.

To facilitate trust, relaxation and rapport with participants, the researcher occasionally reiterated that she was of a similar age to that of the participant, tried to add an element of humour, and talked about topical local events. The researcher used language as a means to increase rapport by relating to each participant in a way that they found respectful, comfortable, and meaningful. When deemed necessary by the researcher, and in line with the observations of the participant, the conversation was re-directed from the termination as a means of encouraging a reciprocal and less-daunting interaction. By facilitating positive rapport, the interview can take on a conversation type format and then evolve as trust between the interviewer and participant develops and strengthens.

In order to ensure that the participant was comfortable, and to give a context for this research, the researcher provided a brief personal introduction and outlined the background for, and purpose of, this study. This flexibility and openness also has been shown to encourage greater self-disclosure and can be beneficial particularly for an initial interview where a participant may be shy, anxious, overwhelmed, or have a lack of confidence in themselves and their narrative (Clark & Braun, 2013). Participants were informed of the importance of them feeling comfortable and safe, and were encouraged to tell the researcher if they wanted to take a break from the interview. The participant was then invited to share her experiences from the beginning. The researcher made sure to validate the experiences of each participant and to maintain sensitivity at all times throughout each of the three interviews with the six participants.

The interview was conducted using a semi-structured narrative approach, based around thematic areas. The themes stated in the interview schedule were used as a rough guideline and facilitated the progression through the main themes. Participants were encouraged to direct the conversation and to tell their own story, which facilitated an enhanced richness of their personal narratives. The participants responded to all the planned themes, although understandably some were addressed in greater depth due to individual circumstances or personal preferences.

Immediately following each interview an opportunity was assigned for the participants to ask questions, to make further comments, or to seek additional clarification relating to the research. The researcher made every attempt to ensure that each participant left the interview feeling comfortable. The researcher did this by facilitating a transition from the past to the present, steering the conversation towards the participant's plans for the day. Other successful strategies included the appropriate use of humour and re-directing the participant towards local events or their unique short-term goals (such as the submission of a forthcoming assignment). Participants were advised that the researcher would 'check in' with them in one week and would email them a summary of their interview.

Participants were reminded of the list of counselling agencies included in the information pack were they to require support following the interview (See Appendix E). The researcher also took particular care to ensure that participants understood the process surrounding the summary interview reports. Likely suitable times and venues for both researcher and participant were also discussed in preparation for the next interview.

Interview summaries were not altered drastically once the researcher sent these back to the participant. Any corrections that were made consisted of minor changes in chronology and the clarification of the wording. Minor changes also were made to the spelling of names and this was rectified easily. Participants informed the researcher that they were satisfied with the information that the researcher included in the summary.

The decision was made to have three interviews for every participant, in keeping with commonly adopted narrative methodologies. Having repeat interviewing allowed participants to review their narratives in between the interviews, thereby nullifying the assumption that a participant can narrate their story within one interaction (Silverman, 2001). Another advantage of repeated interviewing is that it increases the strength of memory by revisiting the same topic on several occasions, and it also gives participants the opportunity to alter and/or to elaborate their narratives. This repetition also helps to foster a co-constructed narrative between the researcher and participant rather than to produce an isolated, time-dependent, brief transcript of a conversation between interviewers and participants (Silverman, 2001). Furthermore, participants are given opportunities to be involved with the direction that the researcher is taking the narrative. This can lead to added insights through further discussions whilst optimising transparency and decreasing the likelihood of control and power being exerted by the researcher on the participant. Whilst repeated interviewing is inherently a very time-consuming process, it can be remarkably time efficient because interviews are summarised and the content is agreed on throughout the interviewing process (Stake, 2000). Ultimately, repeated interviews, with summary reports provided to each participant, is a more transparent and mutually agreed and negotiated process than is possible with a single one-off interview.

Reflexivity

Consistent with a social constructionist methodology, it is important for the researcher to be transparent regarding associated values translated to this research. It therefore was crucial that the researcher undertook self-reflection and conveyed any relevant values and theoretical underpinnings that might affect how the narratives were to be analysed. Narrative approaches consistently emphasised the role of the researcher in constructing narratives and interpreting findings (Chase, 2008). With self-reflection also contributing to the validity of qualitative research, individuals can become both active observers and researchers (Schwandt, 1998). This sense of transparency allows researchers to critically examine how their experiences, values, and beliefs contribute towards subjectivity in research (Schwandt, 1998). Accordingly, it is important to acknowledge that while

scientific paradigms attempt to mitigate subjectivity in research, qualitative approaches tend to promote transparency and critical self-reflection (Ricoeur, 1991).

Being ever mindful of the uniqueness of each narrative, the researcher, at least partially has, negated the possibility of seeking confirmatory statements based on previous understandings of the experience. Regular reflections and writing post-interviews also assisted the researcher with exploring any assumptions or feelings. The decision to persist with a written thesis reflection log thus promoted heightened awareness of any subconscious reactions and provided the opportunity to modify practice accordingly. This log was revisited on a number of occasions and allowed deeper and sometimes alternative meanings to emerge (Thompson & Thompson, 2008). This reflection *on* action process, of course, occurs *after* the event. Opportunities for reflection *in* action also were important because psychology students can have a significant role in determining the direction of interviews (Thompson & Thompson, 2008). A general open mindedness to learning and knowledge therefore permits growth on behalf of the researcher and encourages critical thinking (Thompson & Thompson, 2008).

The presence and role of the researcher

The presence of a researcher, and the potential perception by the participants of the researcher as being an authority-figure, needs to be acknowledged and analysed. As a post-graduate psychology student and researcher, I am aware that there are numerous misconceptions around the role and boundaries of psychological study (Dunn, Baker, Mehotra, Landrum & McCarthy, 2013). With this in mind, the researcher briefly explained the background to the study during the initial interviews with participants. In order to mediate this uncertainty around psychology and the authoritative role of the researcher, various strategies were utilised. These included adapting to participants' schedules and taking every opportunity to build rapport and trust. Further opportunities were provided regarding the position of psychology in society, in particular the emphasis placed in this research on the formation of their own co-constructed narratives. Any anxieties concerning the use or formation of their information would therefore have been mediated (Gamson, 2002).

The researcher must acknowledge that she brings to the research other roles in her daily life; including that of partner, daughter, grand-daughter, sister, friend, and employee. Fundamentally, these roles have been shaped by my life experiences and socio-cultural and historical contexts. At the time of writing this thesis I am a 23 year old woman living and working in the upper North Island who identifies as a New Zealand European. I am the eldest of my siblings and was raised in a middle-class home in the South Island before relocating to the North Island in my mid-teens. For the past three years I have been working in youth based mental health and this has raised my awareness of the range, severity, and difficulty that many New Zealanders face in their daily lives. It also has strengthened my passion for the role and influence that psychology has for New Zealanders and how this can be used in ways that enhance personal and social well-being. In previous working roles I have been involved in consultation with young women who have sought a pregnancy termination to the extent that I have acted as a support person for young women requiring assistance with decision-making.

I therefore am experienced in talking with young women about their experiences in ways that respect their values, contexts and emotions. Whilst some might argue that this prior experience could potentially bias the researcher to approach these narratives with certain preconceptions and views, such previous experience can also be viewed more positively. My prior exposure and encounters with, young women in this situation have led me to become empathetic, competent, sensitive, and tactful in my interactions. This means that participants' well-being is considered to be of the utmost importance and demonstrates a commitment to ensuring strong ethical standards in research. Knowing that this research was not being used to advance a particular predetermined agenda also has helped the participants to feel at ease. By delicately negotiating and navigating through the research process, participants have felt comfortable in disclosing highly personal stories of their experiences.

Case studies

The collection and display of participants' narratives were presented through a case study format. As noted by George and Bennett (2009), case studies are useful

for determining the conceptual validity of concepts such as ‘relationships’ and ‘quality of care’ that are central to this thesis (George and Bennett, 2009). Arguably, such concepts can be difficult to measure and define through the use of statistical methods because they ignore important contextual factors (George and Bennett, 2009).

Furthermore, case studies can generate new hypotheses through conversation such that new variables (and explanations) can be identified and examined (George & Bennett, 2009). Case studies also can explore causal mechanisms in depth, unlike quantitative approaches that often deliberately isolate any intervening variables (George & Bennett, 2009). Case studies therefore provide valuable additional insight because they acknowledge the importance of situational and contextual influences crucial for this study.

Case studies have been shown to be particularly beneficial when exploring both contemporary and historical events (Rowley, 2002). Some researchers view case studies as being most commonly used when researchers are unable to manipulate variables to examine behaviours or feelings (Rowley, 2002). In these instances, case studies provide ‘real-world’ information, rather than research, that is confined to a laboratory setting (Rowley, 2002). Case study information is contextual and tends to incorporate a detailed and somewhat extensive approach to information-gathering that can be useful particularly when undertaking research that seeks ‘how’ or ‘why’ answers (Rowley, 2002). Case studies have the added advantage of providing both an ‘insiders perspective’ on individual cases as well as allowing comparative analyses with other cases (George & Bennett, 2009).

In relation to this study, case studies provide a way of collecting sensitive and in-depth information about an intimate experience such as pregnancy terminations. Ultimately, a case study approach has the very real potential to produce very rich and valuable insights into people’s lives and circumstances, and this has led to a recent resurgence in its popularity among contemporary social science researchers.

Thematic analysis

Thematic analysis was used to analyse the narratives of the six young women who participated in this research. Thematic analysis is guided by the identification and interpretation of meaning, patterns, and underlying conceptualisations and ideologies (Clarke & Braun, 2008). Consistent with Clarke and Braun's (2008; 2013) conceptualisation of how thematic analysis is used in psychology, analysis is a recursive rather than linear process and because they are qualitative they are inherently time-consuming.

Despite the fact that thematic analysis is a relatively popular method of analysis, certainly in psychology and social science disciplines, there are limited guidelines as to how to perform it (Clarke & Braun 2008). While thematic analysis is inherently flexible and can generate rich interpretations, Clarke and Braun (2008) warn that disregarding the 'how' and 'why' of data analysis also can make the analysis method more susceptible to academic and scientific criticism.

Accordingly, the researcher has adopted Clarke and Braun's (2013) four recommendations for constructive and effective thematic analysis. Firstly, considerable time was spent familiarising myself with the data, both within and across participant interview summaries and across these summaries. Data analysis commenced during the process of collection whereby participants' narratives were co-constructed with the researcher. In this sense, data collection was an interpretive activity that involved repeated listening of the audio-recording and sharing of ideas with each participant. This process involved identifying not only semantic or latent aspects of the narrative but also "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998, p. 63).

The process of identifying data codes and associating them with over-arching themes then occurred on multiple occasions to ensure a good fit between the data and analysis (Foster & Parker, 1995). The second stage involved finding similarities between codes to determine meaningful patterns - to use a house metaphor, the codes were akin to bricks whilst themes were akin to the roof (Clarke & Braun 2013). Theme development then occurred whereby themes were

checked to see if they accurately reflected compelling patterns amongst the data and these themes subsequently were re-worked, collated, or discarded altogether. The next step involved defining and explaining each theme and constructing a powerful description. The final task situated these themes and data within the literature. The themes and data were then woven together in order to create a coherent and meaningful construction of the data (Clarke & Braun 2013). Finally, adopting Bazley's (2009) methodology, only themes that were identified as being consistent across at least half of the narratives were included in the analysis.

Conclusion

This chapter has delineated the methodology adopted in researching the bidirectional relationship between pregnancy terminations and intimate relationships and the quality of care received in health care settings. In this sense, bidirectional refers to both the effect on current or future intimate relationships and the effect of relationship dynamics and characteristics for the overall experience. Following careful consideration, a narrative framework was selected as providing the most appropriate means for collecting and analysing participants' information. All of the 18 interview transcripts were summarised by the researcher and provided to each participant for their feedback.

Chapter Four: Participant case study narratives – Intimate relationships

This chapter sets out to present the six participant narratives in case study format as described in the previous chapter. Each narrative will progress through the themes as previously outlined, and this will form a basis for subsequent analysis in Chapter 6. At times there may be additional sub-themes within a theme that are specific for a participant - for example, a participant might make special mention of gender roles and how this relates to, and influences, their culture. This provides the opportunity to include individualised insights and emphasis in the associated narrative. Each narrative begins logically and chronologically, with a description of the life and social context of each participant before she fell pregnant.

Case study One: Jenny

Life before falling pregnant.

Jenny grew up in the South Island of New Zealand and lived with her mother, father, and siblings. Jenny had a happy childhood and was very close to her family. However, at a young age her cousin (who was a few years older) moved in with her due to a family member's death. Jenny's cousin lived with her until Jenny was 16 years old and throughout that time they were very close. Jenny looked up to her and would copy what she wore and how she behaved:

Looking back she was like my idol. She became my best friend and we told each other everything.

Jenny came home one day to find that her cousin had left abruptly and without notifying her of her whereabouts. This caused some tension within Jenny's family and with her cousin's siblings as no one knew where she had gone. Jenny internalised this and felt betrayed that she was not informed about where she was going:

I didn't know where she was for about a year. Then she contacted us and said all these horrible things about how she hated staying with us. I just felt so hurt. We still aren't close

During this time Jenny immersed herself in co-curricular activities, spending time engaged in sports and keeping herself busy. While education was valued by Jenny - she wanted to pursue a career in counselling - she also dreamt of having a family. Jenny had strong expectations placed on her from when she was young that she ought to raise a family and be successful. Success was defined as being happy, financially secure, and having a large family:

I always wanted kids. One boy, one girl I know that sounds silly. I wanted to be a housewife, have a nice home and a husband whom I loved, white picket fence you know?

Intimate relationships.

Jenny began to socialise more often and her school grades suffered as a result. It was through one of her national sport championships for swimming that she met her first long-term boyfriend. Harry* and Jenny clicked instantly and when their team went to the pub for a drink they became close. Soon after this they started spending more time together and realised they had many common interests:

He loved kids. I loved kids. We both had identical passions and this made conversation so easy.

Jenny liked Harry's easy-going nature and believed that he was 'the one'. They had a similar outlook on life where both would not get stressed over little things that occurred in their daily routines. Having such similar dispositions made their relationship relatively stress-free:

Say if we went to the supermarket and someone dinged our car or if we had to get home quickly and there was a crash – it was never a big deal.

We would calmly think oh well nothing we can do about it and move on. It was attractive having someone who understood that.

Jenny grew up in a Catholic family, with her father's side being predominately Catholic. Jenny described how her father's side of the family has a lot of children as they do not practice contraception. Jenny attended church with her family as she grew up but did not enjoy this. However, when she left home she moved to the West Coast to start fresh as she was still missing her cousin and her hometown had too many bad memories for her.

While Jenny lived on the West Coast she commuted some distance to Christchurch to see Harry, who worked at a local school. Jenny was working in a local hotel at the time and worked very long hours, so she enjoyed travelling to meet Harry on the weekend. Harry declared his love for Jenny but expressed his concern that she was losing touch with her Catholic faith. Jenny had stopped attending a Catholic church and only went to a local church occasionally on Sunday. However, Harry was much more religious and clear differences of opinion began to emerge. As Jenny acquired new friends, Harry began to express his disapproval over their sexuality:

I had a few gay friends and they were some of the best friends I have ever had. But Harry was so rude about it – said they were going to hell and said I should not be friends with them. I did not see why he had to be so rude about it and I was in a small town – it is very hard to make friends.

Jenny stopped socialising with these friends and Harry appeared to be grateful for this. However, Harry soon began to question Jenny's faith and made it clear to her that she had to reactivate her Catholic values or else he did not think it was right to marry her. Jenny was distraught by this news as she did identify as religious but was not opposed to homosexuality and pre-marital sex as Harry was. Two years into their relationship, Harry broke up with Jenny based on these religious differences:

It was really sad. We both could not do anything really – religion just stood in the way. I cried all the way back home that night it felt like a part of me had been ripped out.

Culture and religion.

Jenny identifies as Pakeha with her ancestors descending from Eastern Europe. Jenny believes that her Catholic background had made her unsure of her decision to terminate, rather than the influences of her Pakeha upbringing. Jenny believes that Pakeha culture is the most ‘free’ of cultures in relation to choices around pregnancy:

If you are Pakeha and not religious you do have choices. But you bring religion into it, even if you might not be hugely religious, but all those years of religious talk about life – it did eat me away to some extent.

Jenny also described her family as being immensely private. They did not discuss things as a family. The ‘individual’ rather than ‘collective’, was respected. Jenny does not recall learning about contraception at high school and did not think to ask her family about this as it would have been ignored. Jenny’s family believed that such things were not to be discussed before marriage and that intimacy revolved more around how to coach one another through difficult times. Sex therefore was more a means to an end with a child as the outcome rather than the expression of intimacy:

I would never dare ask my mum about sex, it was a no-go and also it would be so massively awkward. Like if people were talking about sex on TV mum would quickly change the channel.

Discovering pregnancy.

A few weeks later Jenny began to feel sick and thought she was coming down with the flu. Subsequently, she missed her period and discussed this with a close friend of hers who advised her to take a pregnancy test. Jenny then discovered that she was pregnant, and was very upset at this news. She did not know what to do

regarding the pregnancy and knew that she did not want to be tied to Aidan. She told Aidan later that day that she was pregnant and he was very open-minded:

He said to me that it was my choice and that came as a surprise to me as I thought he would have told me what to do. I did not want his child but I also did not want to have a termination.

Jenny felt trapped by the pregnancy news as she could not confide in her family as she knew that they disapproved of pre-marital sex and her subsequent pregnancy. Jenny felt that terminations were not morally right but did not know what to do as she thought that she would be ostracised by her family. Throughout the decision-making process, Jenny began to dislike Aidan more as she started to blame him for the unplanned pregnancy:

I know it wasn't just his fault it was mine too. But I was so angry at him like how did I end up in this situation. I was drunk, I wouldn't have wanted to lose my virginity to him, especially not that early.

Jenny and Aidan also began to have a number of arguments around Aidan's use of pornography. Jenny felt strongly that it was wrong for him to do that at his age and that it did not make her feel very good about herself. On those occasions when Jenny pointed this out to Aidan, he would say that he understood where she was coming from but continued to look at pornography. This contributed to the majority of their arguments and increasingly led Jenny to lose attraction to him:

I would wake up in the middle of the night and see him watching it. I don't know if he was like an addict or something but it was so weird.

Intimate relationship with termination partner.

One month after the break-up with Harry, Jenny was still struggling to come to terms with this adjustment. After working a long shift at her local workplace she met a customer who she got along well with. Aidan was very different to Harry: he had a few relationship break-ups (of which he was on the receiving end) and he

worked as a local mechanic. Aidan did not have many aspirations in life, he did not want to travel – unlike Jenny, and was happy to spend the rest of his life living on the West Coast. Jenny started spending more time with Aidan:

We were so different I don't even know why I went there. He was kind of hard to talk to when he was not drunk, he wasn't much of a talker and I really am.

As Jenny and Aidan spent more time together, Aidan repeatedly asked her to be his girlfriend, but she declined. On one occasion, Jenny accompanied Aidan to her friend's 21st birthday where they both become intoxicated and ended up sleeping together. This was the first time Jenny had experienced being so drunk and did not remember what had happened the night before. Jenny was worried as this was the first time she had sex:

When I asked Aidan, he just laughed and said we had sex. I didn't think to ask him if we used protection as I was on the pill for hormonal issues anyway so I didn't think that it mattered. I was certain that the pill would have covered it. I was a bit embarrassed... like that was not how I imagined my first time. It was supposed to be special with a man I am to later marry.

The day after her friend's party, Jenny had a bad hangover and was vomiting repeatedly. Aidan tried his best to look after her by giving her breakfast and renting out a few of her favourite DVDs. Jenny appreciated this and she became more open-minded to a relationship with Aidan. They had the beginning of some 'heart-to-hearts' about life issues and Jenny enjoyed these intimate and philosophical conversations. They started to spend more time together although Jenny still thought about Harry:

It sounds really sick I know and I shouldn't have been with Aidan. I was still thinking about Harry, what he was doing, who he was with, how life could have been.

Although Jenny was fond of Aidan, she knew that she was not in love with him. She admired his liberal approach to life but was not fond of his routinised behaviour where he would go to work and then come home and watch television for the rest of the night. He was loyal and would be there for Jenny when she needed him but he was not spontaneous and there was no real ‘spark’ between the two of them:

You know when you see a couple together and you think yeah they are meant to be. Well not me and Aidan, we always looked awkward when we were out in public.

Jenny was in a poor relationship with Aidan and feared being ostracised from her family if they were to learn of her unplanned pregnancy out of wedlock. Jenny was convinced that she would bring shame on her family if she had a child with a man she was not married to. Therefore, she was more comfortable keeping this termination as a secret from her family. Whilst Aidan was pro-choice, Jenny notes that his opinion (if he was pro-life) would not have influenced her decision as their relationship was not long-term. Jenny considered adoption and was thinking about pursuing this decision. She discussed this with one of her close friends, who knew someone who had been adopted. Jenny went to meet this woman and soon changed her mind as the young woman described how unpleasant the experience was. Jenny notes that termination was not her favoured option but that she felt it was her only option considering how unappealing the other two options were:

It was not like I wanted a termination. It was more because I wasn't in a good relationship. I could not keep the baby and did not want to adopt because the child would be messed up. I also think every child deserves to be wanted and deserves a family with a mum and dad being together.

Intimate relationship post-termination.

Jenny stayed with Aidan for roughly six months following the termination. Aidan was supportive and reassured Jenny that she had made the right choice. He would often do things for her that would help her in her daily life – cook her food, help her with the washing and keep her occupied:

I just needed someone to tell me that it was okay and I am okay, that I'm not a bad person and I am not a sinner even though I know that I am. He kept me busy, so busy that I could not think.

Jenny felt that Aidan was very supportive following the termination, which strengthened their relationship. Jenny began to fall for Aidan and would often think about him while she was at work or out with her friends. She appreciated his caring nature and the loyalty and security that he offered her. However, Aidan then started dropping hints to Jenny that he wanted to marry her and he started to build a picture of what their lives would look like together. Jenny wanted a life partner and a family but began to feel guilty about the termination and still held feelings of resentment towards Aidan for his indifference during the termination process:

Cause now we are really good and we could have had the baby and been happy. I had no proper reason to terminate after all. The more I thought about that the more I got angry and then angry that he was so selfish during the ordeal. Like it was embarrassing for him, hello it was embarrassing for me too! And he wasn't even Catholic.

Jenny decided to end the relationship roughly three months post-termination. Aidan attempted to convince Jenny to get back together and Jenny feels that this was a strong motivator for her to move from such a small rural town.

Subsequent relationships post-termination.

Since this time, Jenny met and married Leon* who is Christian. They met at a mutual friend's baby shower and got along well. Jenny felt as though Leon was flirting at the baby shower and she offered him her phone number. Leon was quite shy and Jenny found this to be very attractive:

Everyone around me was getting married and having kids and he seemed like someone who was really nice. He was very friendly and always had everyone in fits of laughter. He had this sweetness and shyness to him, but

also this really excited extraverted side. That was cool... being so mysterious.

Jenny discovered that Leon was opposed to termination and so she chose to not disclose her previous termination because she did not want Leon to change his opinion of her. Whenever Leon asked her about her opinion on terminations she sided with him and said that she also was opposed to the idea. For Jenny, this represented a missed opportunity for intimacy:

Like if I could reveal all of me, to be unconditionally accepted would be amazing. But I know that isn't the reality. I can't blame him really but it is a bit of a shame.

Within the first month of dating Jenny announced her intentions of wanting to have a child together. As Leon was in his late 30s he agreed and they were engaged within two weeks of meeting:

I don't know maybe it's cause when you get older things just move faster you know.

Jenny acknowledged wanting to find a partner and settle down shortly after her termination. Jenny links this to the idea of wanting to forget about her past, and at the same time, to atone for her actions. Jenny initially found it difficult to reconcile her religion with her decision to terminate, noting that they are polar opposites:

I spoke to a pastor and he said that I had sinned but that god had forgiven me. He wanted me to atone for my wrong-doing and so I have. I have since had a child and plan to have many more. That is how I have found peace.

Jenny has a good and loving relationship with Leon, and they share a similar outlook on life. Leon is ambitious; he runs his own business and dreams of a life that Jenny shares. Jenny admires Leon's enthusiasm for life:

He has got such a get up and go attitude that is something I have noticed. None of this sitting on your ass stuff – he wants to get out there and see the world.

Case study Two: Keisha

Life before falling pregnant.

Keisha identifies as both Māori and Samoan and grew up in Auckland, where she lived with her father and siblings. Her parents separated when she was an adolescent, although she had a close relationship with both. Keisha's parents' separation was predominately due to her father's persistent financial problems. This had an impact on the ability to pay for basics and sometimes meant that their family would go hungry:

I know my father tried to do his best but the way he managed his finances were bad. The further away from payday, the harder things were. I know he sacrificed things for us. He gave us everything he could. He would have starved for way longer than we did.

Whilst at high school, Keisha was a high-achiever academically, socially, and in sport. Keisha represented Auckland in many national competitions, received multiple scholarships, and was singled out to be a future leader. Keisha was so busy with the different spheres of her schooling life that she was not interested in finding a relationship unlike some of her friends. Keisha straddled the differing expectations of her Samoan and Māori sides, with the expectation of obtaining a degree and being more relaxed in terms of education respectively. Keisha was also head girl at her school and was on the path to becoming a dux when her mum passed away. The gradual deterioration of her mother's health led her to assume the position of primary caregiver and in doing so she declined the scholarships that were offered without her mother's knowledge:

I would have had no choice I would have had to accept those scholarships (if her mother was still alive). I wouldn't have been allowed to have made the decision to say no to them.

Following her mother's death, Keisha resumed normal activities very quickly as a way of trying to block out her grief. Keisha was aware of how much schooling she had missed out on and knew her mother would have wanted her to re-focus:

I never really grieved, I just went to school literally the next day and didn't take any days off school for it. I know my sister has grieved my mother's loss for years but I think that is because she feels guilty that she was not there towards the end.

Although having considerable academic potential Keisha was unsure of the career path she wanted to take. This led to a bit of confusion in her family as there was an expectation that she would go to University. Keisha wanted to go to University and enrol in a course but no one coached her through this, especially in the context of her mother's illness and subsequent death.

Keisha had always wanted to have children and this was a priority for her above other ambitions. Having children was a priority above finding a nice partner or husband, and so the desire to have children was evident from a relatively young age:

My goal has never included a man, it has always been me and my kids and I don't know why that is.

Culture and religion.

Keisha's mother had voiced a strong preference for being in control of her fertility and life in general, where Keisha valued independence and self-achievement. Growing up, and since her mother's passing, Keisha felt that she inherited the desire for a sense of control over her life. Keisha related this to financial aspects, having a strong career, and being in a fulfilling relationship. She knew where she stood on the issue of being cheated on and felt that if someone did that to her then it was a "no brainer" that she leaves that relationship. This was a belief that she carried from the outset of her relationship with Tucker:

Because cheating is so much more than just sleeping with someone. Especially with him (Tucker) it was more like an affair. Not just sleeping together but the texts, the lies and the games he played.

Keisha was exposed to the idea of a termination at a relatively young age. This was due to Keisha's mother having obtained a termination shortly after the separation with Keisha's father. Keisha accompanied her mother to the termination clinic, and remembers feeling uncomfortable at the time. As Keisha has adopted both Māori and Samoan cultural values and beliefs she was both concerned for the remains and to do what is 'right' culturally. As Keisha was aware of the strong traditions surrounding pregnancy in Māoridom she tried to convince her mother to bury the remains:

Cause that's the Māori thing aye, you've got to bury it. That's not a Samoan thing. I was trying to convince her that we should take it but she got furious. It is only my generation that is starting to get back into tikanga. I mean my father was from the generation where that was just beaten out of him. My mum used to be able to speak Māori to us but my father didn't know a bar of it. But now, in their 50s they are starting to get back into it.

Growing up Keisha attended a Western based Catholic church, which was vastly different from a Samoan Catholic church. She learnt the Samoan language and became confident and fluent. However, following her mum's passing she became estranged from her mother's family, noting, "we were just way too different". As most of her Samoan family still lives in Samoa, interacting with them compared with family in New Zealand was difficult and she found them hard to relate to. This was particularly pronounced when there were family reunions:

Everything about us, you know. The way we dress, how we talk, they don't leave home until they are married. They all go to University and get a degree. But my cousins have lots of drug and drinking problems, they are very urbanised. Apart from their last name my cousins and I aren't Samoan at all aye.

After Keisha's grandparents passed away, she was given more freedom as to whether she had to go to church. Her mother believed in individual choice and this was a value that Keisha has taken forward. Moreover, from her Māori side, Keisha's family is predominantly Christian. Her father identifies as Christian and encouraged Keisha to adopt this belief system and got to church:

My dad is a Christian pusher. He will push you to go but sometimes you really want him to just shut up.

Keisha attended a bilingual school as she was growing up and valued this opportunity to learn some Te Reo Māori. The teaching method comprised 'teaching to the text' and so Keisha was not given very much practice in speaking the language. Acknowledging the importance of bilingual education, she has enrolled her son in a similar environment, which he has enjoyed. Keisha hopes that her son will be able to speak fluently because while she can confidently understand, read, and write Te Reo, she lacks confidence in producing it:

You never really spoke it. So I don't have that much confidence in speaking Te Reo.

As Keisha was particularly close to her father, she confided in him about the termination, despite knowing his views against it. This decision came from a desire to tell him because they were close, but with the hope that he would not try to convince her to change her mind. Although Keisha values what her father thinks, she acknowledges that he has the right to an opinion but that his anti-termination stance would not make her feel bad about her decision:

I didn't want to because he is very Christian and I knew his stance already. But I have always talked to my dad about a lot of things, but at the same time I didn't want a lecture. I knew he would never disown me, I could kill someone and he would never disown me... and well his opinion is only really an opinion.

While her father did not make her feel guilty, he questioned her reasoning. He also asked whether God had spoken to her about her decision and whether God felt that it was right. Keisha was able to counter this argument by saying that she did not want to be tied to Tucker, knowing that her father and other family members did not approve of him. Her father did not respond to this and, after some time, came to accept her decision although he advised her not to joke about it. Keisha and her father had a very open relationship and this gave Keisha the freedom to state her opinion and challenge his propositions. At times, her father appeared to forget the struggles that their family had in terms of being hungry and having limited finances. Keisha feels that her father does not fully appreciate the costs of raising a child, and has an idealised view that all children need is love:

I rein him in sometimes when he gets too delusional. He has a glorified past. I feel like if you are going to be pro-life then you yourself need to be able to feed your children. Not let them starve for a few days.

In terms of familial history of domestic violence, there was a pattern on Keisha's Samoan side with abuse being commonplace. Despite female family members having more control over the running of the house, they tended to be abused by their husband, or to participate in abuse. Keisha's grandmother was one example where she was abused, but this was not seen as a problem:

My grandmother was a matriarch but was constantly abused by her husband. But that was the norm.

Keisha's mother, on occasions, was abusive with Keisha's father. This was exacerbated when there were stresses with finance, which ultimately led to the demise of their relationship. However, Keisha also grew up admiring her father for not retaliating or raising his voice, and attempting to calm the situation. As violence was prevalent in her family it was not seen to be a cause for concern. Sometimes members of her family would ask what the victim did to aggravate the abuser, with a perception that somehow they had a role to play in the outcome. Having been exposed to violence, Keisha has become desensitised when observing this in her own intimate relationships:

Growing up with violence in my family, has not really made me aware of it, it has made me accept it more easily. So when things have become physical in my relationships I don't leave. The warning bells take a long time to start working.

Discovering pregnancy.

When making the decision to terminate, Keisha wanted to focus her attention on being a good mother to her son and did not want to be connected to her partner, Tucker, through a child. She also had recently broken up with Tucker after discovering that he had cheated on her. When reflecting on her decision to terminate, she noted that both the abuse and the cheating contributed to her decision, although the cheating was more hurtful:

It was definitely a bit of both but mainly the cheating actually. Before I went in for the termination he called me and tried to convince me that I had got it all wrong. It confirmed in my mind that they were talking and made me sure in my mind that they would keep doing that to me. I would be their puppet and I would keep falling into it... I was trapped as his because I was pregnant and he knew that.

Knowing that if she continued the pregnancy, she would have been tied to Tucker through the child, and that this would mean a degree of contact between them, she wanted to “*forget about that part of my life and move on*”. When reflecting back on her relationship with Tucker she feels as though she stayed with him for company, despite him having qualities that she found unattractive. She felt that by having a relationship, regardless of its quality, was preferable to being alone.

When Keisha told Tucker in the middle of their argument that she was terminating the pregnancy he tried to change her mind. Keisha had the feeling that he did not believe she was pregnant, as he did not follow her to Dunedin, despite him knowing that she was there (a mutual acquaintance had informed him). Tucker told Keisha that he still loved her and tried to change her mind. However, she was convinced that he would not follow through with his words and change his ways:

It all makes sense now that he didn't think I was because had he thought that I was he would have flown to Dunedin and shown up at my house. He was that kind of psycho.

As pregnancy terminations were a relatively familiar experience in her family, Keisha was able to approach her cousins for advice. Keisha knew her cousins would be helpful because they had had terminations and they knew what to do, even if one had had a bad experience. As her cousin had previously had a termination, she took control of the situation, and organised appointments. Keisha was firm in her decision-making, having been hurt, and knowing that a new and improved life would unfold after the termination:

I knew that my cousin was not fine with the termination mentally because she would get drunk and cry about it, but I knew I would not be like that.

Intimate relationship education.

During her schooling years, Keisha was taught that abuse in a relationship was unacceptable. However, Keisha and her classmates were not taught what abuse looks like and the variations of abuse, including mental and emotional abuse in addition to physical. Keisha was also not taught what to say or do if she found herself in that situation and how to access community resources. Keisha links her experience with relationship abuse education with the current 'It's not okay' advertisements:

They are not helpful. It also does not tell you how to help someone who is in an abusive relationship. It does not address those day-to-day problems like who looks after my daughter when she is sick and how do I get help to leave.

Keisha was taught about sexual activities and the various consequences that can occur. At school a representative from Johnson and Johnson presented facts and signs of a sexually transmitted disease (STD) on an overhead projector. The focus for this education was on prevention rather than intervention, and there was no

education or information provided about what to do if you find yourself pregnant. There was a girl in Keisha's class who became pregnant and so she knew from her that the process was confidential, where you saw a nurse and the nurse was not legally allowed to tell the student's parents. While Keisha found school-based sex education interesting she learnt most of her contraception and sexuality knowledge from her older sister.

Growing up Keisha witnessed a number of relationship breakups in her immediate and wider family. Keisha looked to these relationships for guidance about what a 'good' relationship is, how to recognise signs of flirting, and the various complexities of personal relationships. As she experienced no education on intimate relationships - what they look like, what to do in an abusive situation, how to flirt, and how to end a relationship - her immediate family context became her personal reference point. By observing these relationships, that a relationship where arguing was common, she knew that these relationships were not the ones she desired:

I think there are a lot of people in this generation who I think are not going to have very good role models. My children for one (referring to their father). I have an auntie and uncle who have been married for years but they constantly bicker. I would not want a relationship like that. I don't have anyone in my family that I look at and think yeah I want a relationship like that.

Intimate relationship with termination partner.

Keisha was at one of these parties when she met her first formal relationship partner – Tucker. She was not drawn to Tucker physically and disliked his lack of ambitions but she noticed that he had some charm about him and he was chivalrous. While the Samoan side of her family did not warm to him either due to his looks, her Māori side felt that he was a nice man with honourable intentions. However, in private, with no witnesses, Tucker was very controlling and abusive. Outwardly, it appeared that he was subordinate to Keisha and there appeared to be a change in behaviour when he was in the company of others. Behaviourally,

Tucker frequently shifted between these ‘private’ and ‘public’ metaphorical masks:

He would always be there for my family when they needed help. He would share a drink with them and he made it seem like he was down to earth and all my family could see was me bossing him around. I knew I could rely on him but he was kind of fake in a way. In saying that he was quite a positive person. He would like people who liked him. He liked to be liked and was caring to others in the start anyway.

In the beginning of their relationship, Keisha took time to form any sort of attraction towards Tucker. It seemed as though he appeared at a time when Keisha needed an outlet. He was a welcome distraction, and appeared to put his ‘best foot forward’ in the initial stages of their relationship. Despite her Samoan side of her family not liking him, Keisha protected Tucker and told her family that she loved him. On one occasion when Keisha was stranded somewhere at a party Tucker came to her rescue:

It took me a long time to like him I didn’t like him even after I had slept with him. I needed an escape from where I was living with my auntie. I think she was secretly bi-polar. She was constantly on a rollercoaster of emotions and he was a very good escape.

Keisha and Tucker’s relationship progressed quickly, as Keisha did not feel comfortable about approaching the opposite sex and therefore felt that he was one of few who found her attractive. Keisha also lacked dating experience or the confidence to pick up the subtle signs when a potential partner is flirting with her. Keisha therefore agreed to a relationship with Tucker as he was very open about his feelings, something she had not experienced before. Consequently, Keisha interpreted Tucker’s openness about his feelings as being the only way a man demonstrates an attraction towards her:

Because I never dated as a teen, when I did meet him (Tucker) I didn’t know what to do. It went from just meeting him to being in a relationship. I

*don't think I have dated in my life. I think it is hard to be picky with partners when you don't have that skill set to know what you want and to filter out the bullsh**.*

After she moved in with Tucker, problems began to emerge between them. Keisha discovered his pattern of lying and soon learnt that he had two children from a previous relationship. Tucker also had not told her that his ex-girlfriend was pregnant when he and Keisha had met and that he was still occasionally sleeping with his ex-girlfriend:

Looking back, my life was unbelievable. It was like I was living Shortland street. I confronted him about it but he beat me up and I stayed with him. I was determined to stay there for no real reason – don't know why. I distanced myself from my Samoan side during this time because they thought I could do so much better.

Tucker then broke up with Keisha, which led her to contact a former boyfriend, Pita. This was a big change for Keisha as her life with Tucker was very relaxed as he lacked any ambitions. The successful life that Pita lived was a huge change from the life she had with Tucker. Keisha did not like this because it reminded her about what she had lost by declining scholarships and not pursuing university study. It also appeared that Pita was preoccupied with study and that they were at different stages in life. Regretting this, Keisha went back to Tucker and it was then that she discovered she was pregnant with Pita's child.

Upon being told this, Pita said that he would support their child but was not ready for a child and wanted to be away from Keisha, as he felt heartbroken. Keisha went back to Tucker and told him that the child was his. Tucker became a good father and bathed the child and took real responsibility bonding with him and making sure to never let him down. Tucker now became an inseparable part of Keisha's life and he seemed much more stable which made her life easier:

He became the most amazing father, worst boyfriend but best father. He would give me some time to myself; he made himself indispensable to my life to the point where I couldn't imagine things without him.

Having moved back in together Keisha soon discovered that she was now pregnant with Tucker's child. At the same time she found text messages from Tucker to his ex-girlfriend. The hurt and betrayal that this caused made the pregnancy not seem special, as Tucker already had children. The lies made it seem like he was living two different lives, and that effectively he was having an affair:

I didn't want to be the next girl because, you know, he already had two kids. I felt betrayed as he had made it seem like his ex-girlfriend was the one that was harassing him; he would say things like ew I hate her, she never leaves me alone. He was telling two different stories– saying to her oh I am only here because her kid is messed up and needs someone stable. I don't really want to be here.

After discovering these texts they had an argument and Keisha asked Tucker to leave their home. During the course of their argument she told Tucker that she was pregnant with his child and that she had decided to have a termination. Tucker became physical, punching a hole through the wall and throwing objects around the room. Tucker later made a police statement alleging that Keisha had abused him and subsequently she was arrested:

I shouted at him but I definitely didn't lay a finger on him. He then told me that he would drop the charges if I came back to him. I think he cheated because I was trapped as his because I was pregnant and he knew that. He was one messed up guy, I still don't understand why he did that to me and I don't even try to.

Intimate relationship post-termination.

Years after the termination, Keisha was cleaning out her room and contacted Tucker to ask him if he wanted the ultrasound photo. Tucker was curious, noticed the scan date, and then looked genuinely surprised:

It really hurt him to see that photo; I could see it in his eyes. This is going to sound sick but it made me happy to see him like that.

For Keisha having the ultrasound scan photo was not only proof that she was pregnant but also an acknowledgement of the hurt that he had caused her. For the first time in a long time, Keisha was in a position where she exercised some control over her life and the decisions that she had made. This photo seemed to illustrate a sense of empowerment and control about living a life that Keisha would be proud of and satisfied with.

Subsequent relationships post-termination.

Following her termination, Keisha met Hemi, who worked in the trade industry. He had pursued Keisha for years but she was not attracted to him. Then after some time Keisha gave in to his persistence and felt more ready to have a relationship. Their relationship, like her relationship with Tucker, progressed quickly. She moved in within weeks and they soon became engaged:

I thought oh well he's all right and he likes me and he was pursuing me, good enough... I have told my friend that I have been with the only 3 men in this world who find me attractive. With flirting, well... it has either never happened to me or I just don't see it which sucks. I would like to have that subtle fling with someone but I don't understand it.

Initially, Hemi was very caring, easy-going and positive – qualities that Keisha found particularly attractive. He was very positive and their personalities complimented one another. Hemi had a refreshing perspective on life and was carefree in response to potentially stressful situations involving friendship fallouts. He prevented Keisha from ruminating and allowed her to see things in a much more positive light:

He would just say, you know, don't worry about her, she is nothing, you are so much better than her. I found that very attractive because no one has ever told me to shut up. He was really blasé about life in general, he

was very laid-back and I am quite uptight. If I get away with it I will just go on and on about things but he would pull me out.

After getting to know each other better Keisha discovered that he was opposed to terminations and therefore she decided not to tell him about her previous experience. He was very strict about this and when he talked about it from time to time she would brush it off. Keisha did not feel guilty for not telling him because she felt as though it was a private matter and something that she would rather forget about. Sharing the story of her experience meant a high likelihood that she would be judged, and that she would need to explain her abusive history again. Keisha acknowledges a discourse surrounding the justification of certain terminations, in this instance, terminations on the grounds of sexual assault is often commonly accepted whereas other circumstances surrounding termination are not understood and socially approved of. She felt a sense of stigma having had two children with different fathers and admitted that a termination would strengthen any stigma she already experiences:

I wouldn't want to be that girl who had more than one termination... my cousins are fine with telling people, but not me I don't want to be judged. I would then have to get into the conversation of why did you give this one life and not that one. I already have two kids to two different fathers.

Hemi's anti-termination stance became stronger following a work-related brain injury resulting from a severe fall. Following this and after repeated miscarriages whilst trying for a baby, Hemi also became more controlling as their relationship shifted to focusing on having a child together. Until this point Keisha had not reflected at length on her decision to terminate post-termination:

There was a moment when I wondered am I being punished for having a termination. That wasn't a nice feeling.

This process was stressful for both of them and Keisha was supporting Hemi emotionally through the process, akin to being a life coach. Because this one-sided support was frustrating and draining for Keisha so she sought advice from

her auntie who normalised this and related this to her role as a wife. Hemi restricted Keisha from playing sports due to the fear of miscarriage and she found this to be suffocating:

He had no filter he would just flip.... He knew what to say to hurt me and he knew how to control me. I thought he wasn't insane because he picked his targets. If he really had an intellectual disability then he wouldn't discriminate. He was more emotionally abusive than physically like some of the things that used to come out of his mouth man... He was definitely below the belt some of the stuff. He could just bring up my worst fears and just throw them at my face.

Hemi began to isolate Keisha from her friends and family so that she could cater to his demands and needs. Although he never seemed grateful for her changing her dreams and plans for him, he continued to expect that she would follow his decisions. Often Hemi would pretend that he wanted to be with Keisha's family gatherings but then complain to her afterwards that she made him stay. He would often swear under his breath and she knew that there was going to be trouble at some stage. These mind games frequently led to arguments later on. These arguments often brewed for months and would be raised by him during yet another argument. Keisha could not remember these past instances, which would further infuriate Hemi. This was an example of an abusive tactic known as 'gas-lighting' whereby the abuser twists or omits information to favour oneself. 'Gas-lighting' can also occur when false information is conveyed to the victim with the intentional effect of the victim doubting their memory or perception:

He would use my fish memory against me to try and prevent me from going out with friends. He would say remember what happened last time, you got drunk and you wouldn't text. It was easier for me to not stand my ground because then there was no risk there I guess. I guess I couldn't predict very well. I wasn't good at predicting what he was thinking.

As Keisha increasingly became isolated she did not tell friends or family, or seek their advice about the situation for some time. Keisha also mentioned her Samoan

side and upbringing where she witnessed her mother hitting her father. For her this validated and normalised experience of domestic violence helped her to confide in her family about the abuse. However, they partially blamed Keisha for Hemi's behaviour:

I remember telling my auntie from my Samoan side about it and she said it's probably your mouth. You know you always run your mouth it is probably your fault. Then it took them a long time to realise that it actually wasn't me and then they got angry about it for me not telling them.

Hemi and Keisha went to a couples' counsellor and tried to work on improving their relationship. Hemi was always very apologetic and often would cry and beg her to remain in his life. Keisha became confused as Hemi obviously was upset and sorry for what he did but the domestic violence kept occurring. There also were logistical issues that made separation more difficult, both practically and emotionally:

It was a really long drawn out process. I would think he was getting better then another incident would happen. He was always so sorry that he did it but did not verbalise why he did it. I would say to him one more time and that is it. I meant it when I said that but I just couldn't get him out of my house; that was the hard part. I would say to him I'll get you a place to stay and then you can leave. But then I would find him a place and he still wouldn't leave. It was a long process of we aren't together, I hate him but I had to bribe him with things to get him out.

Finally, the domestic violence escalated to such a point that Hemi was eventually trespassed from the family home. However, shortly after this trespass notice, Hemi visited Keisha's home and physically assaulted her to a level previously unknown:

Pretty sure he was trying to kill me. He then held my children and I captive in our own house. He's so not right in the head. When he gets out I'm pretty sure I know where he is coming.

When reflecting on future relationships Keisha admits being very weary because of her two abusive prior relationships. However, she is hopeful that she will find a life-partner and acknowledges that she has lost confidence. She wants her next partner to be a stable individual for her and her children. However, she hopes that she will take more time to get to know someone before wanting to commit to marriage so soon after meeting one another:

I've come to learn that I am going to end up with an asshole. I just don't want an abusive asshole you know (Tucker) has really put me off guys. I told my family the other day that I am ready to meet the asshole that I am going to get. Like I know he is going to be an asshole in some way so let's just get it out of the way so we can live our lives together. I am convinced that I do want a relationship and want to marry and grow old together. At least it would be a stable person for my children and for me too. Just a witness to my life... and for company. I don't want to get to the stage where I was with him where someone shows me the eye and I think yeah I'll marry him.

Case study Three: Arietta

Life before falling pregnant.

Arietta grew up in the Central North Island and comes from a large family. Arietta identifies as Māori/NZ European with her mother's side predominately Māori and her father's side predominately Pakeha. Although Arietta identifies with Māori values, when growing up there were occasions when there were family feuds over decisions and experiences of *whānau*. At times, these two cultural systems clashed and had to be negotiated, allowing Arietta to acknowledge and value aspects of both her ethnicities.

For as long as she can remember Arietta always had envisioned having a family. Whilst her family encouraged her to succeed in education – whether that be through polytechnic, university, or starting her own business, Arietta always imagined herself to be a mother foremost with her taking second place. Arietta got along well with her mother. However, as she was the eldest, this sometimes led to heated family discussions regarding her choice of boyfriends:

You know, cause I'm Māori, Mum wanted me to be with a Māori fella. She always had a thing about it... I was never the kind of girl who chose someone just cause of their background... If I fell in love with a Pakeha then it would have caused tension so that was hard.

Arietta enjoyed her secondary schooling but felt uncertain about what she wanted to do for a career. Her family supported her decision to have a gap year and to work fulltime. During this gap year Arietta developed a passion for the fashion industry and began to plan a course in fashion design for the following semester. She also enjoyed having the time to socialise and to meet the opposite sex, as she had attended an all girls' school:

Man I was so embarrassed when I would talk to a guy... such a dork like I'm Māori but look at me (laughs) and I go tomato red. I used to stumble my words and yeah... maybe that was why all my mates got a boyfriend so easily and I didn't.

Culture and religion.

Arietta got along well with her siblings and was particularly close to two of her sisters. She supported one of her sisters in getting a pregnancy termination and accompanied her on the day. However, her mother and father made it clear that they disapproved of her sister's decision to conceal the pregnancy and eventually to terminate:

*It got pretty nasty. My mum and my koro did not hold back and the relationship between my mum and sister is still bad - they don't talk. My sister felt sh*t about it in the first place then my mum couldn't help but*

guilt trip her. Like I knew that it was a no-no (to terminate) in our family. I guess I kind of get it with my koro, cause you know, he's old. But seeing what my sister went through with mum, like wow. It was hardout aye.

Arietta and her family were (and still are) members of a Presbyterian Christian church. Arietta enjoys the values and traditions that her religion offers but also believes in the right for others to decide on their own religion. She has a mixture of friends from different religions, cultures, and socio-economic backgrounds and believes that this has provided her with different perspectives and ways of seeing life. Arietta sees herself as being accepting of diversity and dislikes others forcing their beliefs or values on others:

Maybe it's my generation. I don't know. Cause just cause you think or feel something doesn't mean someone else is feeling the same way. Like I would never force my beliefs onto someone else but I have mates that do. It's like oh man shut up, let them think what they want it's their life.

Arietta remembers being teased in her schooling years due to her comparatively different appearance from her siblings. Arietta describes herself as being a “white Māori” and has taken aspects of both Māori and Pakeha culture into her everyday life. Following her teenage years, Arietta undertook a self-examination of cultural awareness and identity by speaking with her *whānau* and now feels more secure and proud of her heritage. Although she is currently able to speak Te Reo Māori, this is usually not spoken outside of the familial home as Arietta frequently is not given the opportunity. Historically when this opportunity was presented Arietta would conform to other people's expectations and assumptions of her:

People look at me and just assume. At school kids used to laugh at me like oh you aren't Māori you are just a wannabee and that was from kids of all cultures. I didn't really know who I was and I couldn't look to my sisters for guidance cause they look more Māori than me. Sometimes it was easier to nod and say yeah I'm Pakeha. I would justify it to myself in a twisted way.

Discovering pregnancy

Arietta and Mark had been a couple for two months before they discovered the pregnancy. Arietta was on the combined pill and she was adamant that she had been taking it correctly. She had been on the pill for a number of years to help moderate her acne. The pregnancy came as a complete surprise because she was on a reliable form of contraception and had a period while pregnant. The pill was the best choice for Arietta because she felt that condoms were awkward and would detract from the experience for Mark:

*And it killed the moment (condoms)... like an umbrella in the rain or whatever guys say. I didn't want our sex to be half-ass. The pill is supposed to be 99% effective if you take it right. I definitely took it right. Grapefruit juice, antibiotics, St Johns Wort – yup I knew all those interactions and I still got knocked up. What made it even buzzier was I had a period and when I had the ultrasound later on I was like holey sh*t. So yeah, didn't know you could bleed and be pregnant.*

For Arietta, not knowing the reason for falling pregnant was difficult. Although Arietta had always wanted to be a mother, she also wanted to raise the child herself. She felt strongly that if she had told her family about her pregnancy her whānau would have taken the child from her. Arietta notes how she gets easily attached to people and places, and so felt as though *whangai* (child is raised by a relative) would have been hard. For Arietta, knowing how the contraception failed was important for her to understand her situation and to find some peace:

If I told people that they'd be like err there is only one way you can get pregnant and laugh. But seriously... I don't remember what I did wrong and it bugs me.

Arietta went to an after hours doctor, having felt more tired than usual and suspected that her iron count was low. The doctor performed a routine pregnancy test and Arietta had shrugged this off, telling the doctor that she would not be. It came as a shock when the doctor said that she was pregnant. Arietta remembers crying at the news and the doctor had to quickly find some tissues:

I had a new boyfriend who I was not overly in love with and was planning on leaving. Plus I never wanted a termination because that just was not how Māori roll. Well my whānau anyway.

When Arietta confided in Mark she was surprised by his reaction. Mark made it clear to her that he was not ready to be a father and listed all of the reasons why she should not continue with the pregnancy. Mark mentioned that he was young and did not want to have different children to different mothers, and this made Arietta upset and angry. Their conversation escalated to the point of shouting and Mark mentioned that he would leave Arietta if she decided to keep their child:

What kind of a man does that? I was so naïve, I didn't know how he would react but I thought maybe there was a slight sense of wow we created this life but nah. He couldn't care less and was trying to threaten me. Looking back I was clingy, some desperate little Māori girl who wanted my first relationship to last. Especially cause my mum said that it wouldn't last. Just wanted to stick it to her.

Over the next two weeks Mark gradually accepted the idea of it predominately being Arietta's choice. He said he would be there for her as much as possible and that he was genuinely sorry for getting emotional but that he was in shock. Although Arietta tried to forget about this 'hiccup' and continued with their relationship, when decision-making was discussed Mark continued to change his mind about the termination:

*He would say oh babe I want you but we aren't ready then next minute let's go for it (keep the pregnancy). He kept changing his mind and it made our relationship spiral out of control. It was sh*t to begin with don't get me wrong, but the termination made it even worse.*

Arietta noted the tension between her cultural background that placed emphasis on carrying on whakapapa and her current financial and social predicament. For Arietta, being unable to care for her child due to this predicament would have led to *whangai*, which Arietta was uncomfortable with. This was because Arietta

feared that she would change her mind about *whangai* after the birth. This was an important factor for Arietta that led to her decision to terminate:

Like it didn't sit right with me deep down in my gut. Mum had always tisk tisk women who aborted, said they were losing their values... I don't know...I was so confused. Then again I couldn't really see a way out. Whangai would have been so hard so yeah termination was in some ways less painful.

Intimate relationship with termination partner.

While Arietta was enjoying her gap year she met Mark, her first boyfriend. Mark was a mutual friend and they met at a local youth group. Mark was Pakeha and whilst Arietta knew that her *whānau* would not approve, she agreed to spend more time with him. Arietta admitted to being eager to explore sex as her friends had been doing so in their late teenage years and Arietta had felt left out:

Like for me it wasn't a big deal, I was never saving myself for marriage. My friends would talk about it and I would just feel so left out. I wanted to see what the excitement was all about.

Mark and Arietta spent a couple of weeks worth of dating before officially becoming a couple. Arietta was primarily attracted by Mark's appearance and was proud that he would frequently get admiring 'looks' from other girls. This boosted Arietta's self-confidence, knowing she was with a man who was good-looking:

Like he chose me and he could have had anyone. He was so sweet to me too, always calling me cute pet names and 'gorgeous', 'beautiful' – it would be hard not to like someone who always says that.

Prior to forming a relationship with Mark, Arietta did not have a clear sense of what kind of a partner she desired. Through her friends' relationships she had some idea of the characteristics she disliked such as arrogance, selfishness, self-absorption, and physically abusive. She was excited to have her first relationship

and to be included in conversations that her friends had. However, the journey towards beginning her relationship was met with a lack of any real expectations:

Yeah I didn't have many expectations. Man that sounds bad but you know... I just wanted to join in on the fun. If the relationship wasn't for me I would end it but yeah I just had no idea what to expect. Like all the subtleties, is he looking at me? How do I know if he likes me? So complicated this relationship stuff.

As the relationship progressed, Arietta began to see signs in Mark that were unattractive. He became increasingly controlling and would frequently make Arietta feel guilty when she would catch up with her friends. As Arietta's confidence grew throughout their relationship (due to the reduction of her acne and loss of weight through diet and exercise) Mark disliked the attention Arietta received from other men. Often he would comment that she still had a lot of weight to lose and that the men were being 'desperate'. Instances such as these led Arietta to contemplate leaving the relationship. As she was in the process of planning their breakup she discovered that she was pregnant.

Intimate relationship post termination.

Arietta and Mark remained together for roughly four to five months after the termination. Whilst Mark was angry on the day of the procedure, he became noticeably more supportive in the months that followed. He tried to help Arietta with writing her assignments for her course and did household tasks. Nevertheless, Arietta found it hard to forget the reaction of Mark on the day of the procedure and she felt a growing sense of resentment and ambivalence towards him:

I just couldn't forget what an ass he was that day. Like could he not have thought about me and been less selfish?

Mark attempted to connect with Arietta about the experience and tried his best to express empathy. Arietta noticed that Mark seemed to be very happy and wrongly

thought that having been there on the day they would take the same time to adjust back to normality. For Arietta, having observed a noticeable change and improvement in Mark's personality led her to assume that the experience of a termination were similar for both of them:

I guess I was a bit jealous. Like I kind of wanted this to be something we grow from but he was just on a different level. Looking back in many ways I used him as a support cause it was great being with someone who was so happy. He had calmed his controlling ways too, that was a big change.

Arietta then discovered, and finally accepted the reality, that a *shared* experience does not mean the *same* experience. Arietta found that burying the remains near to her ancestors graves provided her with a great sense of peace. Having a place to come back to, and at times, to meditate, allowed Arietta's experience to become a reality for her, rather than a forgotten event:

Cause you know people don't talk about abortions. I didn't even know my friend had one till I was considering one. Kind of like Pakeha and death aye... it's all a hush hush thing. For Māori, we see the wairua and we breathe it everyday. To me, that is all I've ever known and I am definitely at peace.

Arietta initiated the breakup of her relationship with Mark. She found that her relationship revolved mainly around being close to Mark who she thought could be a good support person as he was so closely involved in the situation. She soon realised that this was obscuring aspects of her relationship that were dull and unsatisfying for her. Arietta noted that because her friend was the only other person who knew, she relied heavily on Mark for support. The relationship became overshadowed by the termination, rather than providing an opportunity to establish themselves as a couple:

It became this all encompassing thing. I couldn't talk to anyone else really cause of the stigma. My friend got it in some ways but I think after a while

she was sick of hearing about it. I suppose Mark tried his best, in his own limited way, to help me.

Subsequent relationships post-termination.

Since this relationship, she has met Rangi*, a successful Māori mentor. Arietta and Rangi dated for a number of months before officially becoming a couple (when Rangi asked Arietta to be his girlfriend). Arietta decided to take a more gradual approach to the progression of this relationship. She took time to enjoy the initial 'honeymoon' phase of their relationship, which included getting to know one another and doing fun things as a couple such as date nights and going away for romantic weekends.

Arietta noticed that she has also become more cautious in terms of her sexual health. Arietta asked Rangi about his previous sexual history and used condoms for their first few encounters, something she did not do in her previous relationship:

I guess being in that situation (having a termination) makes the whole having kids thing a lot more real, not so distant. So it sounds weird but I really get how you can end up with a baby if you aren't super careful.

Rangi and Arietta discussed quite early on their values concerning controversial issues such as euthanasia and what they wanted from their future. Arietta did not hold back from making it clear to Rangi that she wanted to have a family and was happy to hear that he felt the same. However, Rangi identified early on as being a pro-life supporter. Whilst Arietta tried to keep an open mind about this she decided not to tell Rangi about her experience of a termination:

I just didn't want to go there. He would look at me differently and it's all in the past. I mean I go to the burial site but I do it alone. I mean if he found out somehow I would feel real bad and I guess it might open up the whole well what else are you hiding from me.

When reflecting on other ways that the termination may have had an impact on her relationship with Rangi, Arietta notes that she has become more discerning with Arietta's first relationship there often was a clash of belief systems and values that made it more difficult for their relationship to become more intimate. Moving forward, Arietta noticed how having the same values on 'big life' and controversial issues was important:

Cause you know like a termination or like euthanasia. You never know when you are going to need to have those talks. I might be with Rangi forever and I might get ill. If he was anti euthanasia then I might suffer towards the end of my life. These events are not so far removed I feel.

Case study Four: Isabelle

Life before falling pregnant.

Isabelle was born and raised in the central North Island and comes from a large family with both older and younger siblings. She identifies as New Zealand/European and had a close relationship with both parents and siblings. During her adolescence, her mother passed away after a battle with a terminal illness, which left her father to raise the children alone. Growing up, Isabelle was exposed to her mother's respect and passion for gender equality and the right of women to choose regarding whether or not to terminate a pregnancy. Despite being exposed to her mother's liberal left-wing beliefs concerning the rights of women, her father became notably more conservative following her mother's death. For Isabelle's younger siblings, they also seem to have adopted a more conservative standpoint compared to their older siblings:

I care about what he thinks in a stuffed up way. Like I don't know why but I have always been like a daddy's little girl or whatever. He has always been really progressive like pro-gay marriage, pro women's rights, pro-choice. But he has started to change and is becoming more conservative so I hope I don't hear him talking disparagingly about abortion. Like my

younger brothers and sisters are growing up so conservative and I'm like what?!

Following her mother's death, Isabelle was raised in a single-parent family, which she felt influenced the family dynamics. When her mother was alive Isabelle Before her mum passed, and her siblings could be selective as to who they would ask for permission or her parents would come to a mutual decision. Afterwards, the family dynamics changed and her father became the final decision-maker:

Some single parent families absolutely rock it. But I mean it could just be my upbringing that has made the nuclear type family look that much more appealing. Having a support person to co-parent is important whether that is a grandparent or a partner, someone to share the parenting load to me is a big deal.

Growing up, Isabelle learnt of experiences with other family members who considered a pregnancy termination. Whilst her mother advocated for the rights of women to choose, she herself did not decide on a pregnancy termination when she discovered that she was pregnant. Learning this information allowed Isabelle to mull over pregnancy terminations in order to discover her own beliefs and values. However this knowledge came to the fore when Isabelle later was engaged in decision-making regarding whether to terminate her pregnancy:

I guess it has been very hard to reconcile that view when I faced a lot less tough of a dilemma and I chose the other option but you know... it is what it is...She was a bad ass feminist (mother) but she was catholic. She was for a women's right to choose but she couldn't terminate personally. She had cancer and then it came back, that same week she found out she was pregnant with my youngest sister. Everyone including doctors and my dad tried to convince her to terminate to give my mum a better chance of survival but she didn't.

Isabelle identifies as being ambitious and was an undergraduate student in Auckland. She enjoyed her first year of study and because she missed important

enrolment deadlines, she was unable to take core papers. She enjoyed the flexibility of taking a variety of electives that partially assisted her in forging her career path. Isabelle was in her first year of study when she became pregnant.

Culture and religion.

Coming from a New Zealand European cultural background. Isabelle notes the tension between the necessity and reality of grief following a termination and the dominant view that somehow women have ‘brought this on themselves’:

It is like people feel that you are allowed and expected to feel shame. You should feel bad for what you did but that if you feel bad for too long – it is like well you can't feel that way because you chose this decision. It is such a mixed bag of emotions you feel relief but then you feel bad for feeling that way and argh it's so complicated.

Whilst Isabelle identifies as New Zealand European, she expresses her dissatisfaction with her culture's reactions and understanding of grief:

It's like you put them in the ground then eventually you try and forget about them or you know, you try to move on. People are understanding to an extent but you know a year later people might be like oh why are you still so sad about it. You can't put a time limit on grief, like you can't even put it in stages, you are always changing from one stage to the next then backwards. Like there are compartments of grief that you never realized, when I lost my mum at a young age, there are moments in my life even now where I really grieve that.

Grief within a New Zealand European cultural context comes with a series of expectations. These expectations can be viewed as an attempt to assist oneself to function adequately in everyday life:

We are so future orientated, maybe live in the moment to an extent. But we really frown upon living in the past. Even in the preparation for my

termination I just thought oh well let's do this. I was not really aware of how I might feel afterwards.

Discovering pregnancy.

When Isabelle discovered she was pregnant, she was very shocked and cried hysterically. Whilst she has always imagined herself to have children one day, she did not expect to be pregnant because she had been on the contraceptive pill during her early teenage years due to heavy periods. However, after some time she felt that she would take a break from all of the hormones found in the combined pill and so she switched to the mini pill:

I mean it is great if you are an organized person – where you can take it at the same time every night. This was not me unfortunately. I feel like I thought I was invincible like oh that would never happen to me (unwanted pregnancy) I am way too smart for that. But then it happened so.

Isabelle delayed informing her partner as he had examinations and she did not want to stress him further. Moreover, she was very nervous about his reaction and knew that once she informed him, the situation would be very much 'real'. Her partner Henry did not indicate a preference for termination, adoption or keeping the child, which was a little bit frustrating and certainly overwhelming. However, in the short-term, it was comforting to have his unconditional support and preparedness to take self-responsibility. Their relationship strengthened once Isabelle had received this support from her partner. Nevertheless she felt that the weight of this important decision resting solely on her:

Until the nausea kicked in at least. We were really connected after then, we spent the day at rainbows end then just came back home and yeah. It was nice to know that he had my back... He supported whatever I wanted to do. But at the same time it made it really hard because he didn't give me any indication one way or the other. I didn't want to put him in a life or deprive him of a life that he wanted. I mean it's hard because I should

be grateful and I am grateful but at the same time it felt like a shirking of responsibility, it was all on me.

Despite identifying as pro-choice, the decision-making process was difficult for Isabelle and was compounded by bouts of severe morning sickness. This affected her concentration, preparation, and performance in her university examinations. This morning sickness contributed towards a negative experience of pregnancy and was a partial factor for seeking termination. However, ultimately being in a novel relationship and not being financially secure were the main reasons why Isabelle sought a termination:

I had the worst vomiting where it comes out my nose. I just saw no end in sight and so the morning of the D&C that morning sickness disappeared like straight after. Surprisingly the nausea was actually a bit of a factor for me. Because some people go with pregnancy and have morning sickness throughout – you just don't know. If I had been glowing it would have possibly made the experience more happy. It doesn't put you in a positive frame of mind. I mean that (nausea) wasn't the only reason – I'm not that shallow.

When making the decision whether to terminate, this included consideration of whether she was ready to be a mother. Although the desire to have children was strong, the stress of having an unplanned pregnancy and the associated timing was stressful. For Isabelle, timing was a significant factor as she was in her first year at University and also was in a novel relationship. Isabelle and her partner had been together for four to five months and this was a significant factor in termination decision:

I kept looking at him and thinking I don't know if I want to spend 18 years with you. I know you didn't have to have a nuclear family situation but having grown up in one that was kind of important for me, to at least try to have that.

Because Isabelle was pro-choice prior to falling pregnant, this made the decision-making process a little bit more seamless. In this instance, being self-aware of

values and belief systems removed an additional element of self-investigation and reflection when engaging in decision-making. Although pro-choice Isabelle was surprised that she felt so ill prepared for the tension and emotions involved in arriving at her decision to terminate:

Being pro-choice didn't take away from the fact that it was a rough time. I guess I didn't quite expect that or how I would feel afterwards. I mean it was explained to me how I might feel but nothing really prepares you for this. I mean I was so nauseous most likely from the hormones but in a way I think it was also probably stress-related. I had exams on at that time too and I tried to compartalise it and think – let's just get through these exams first. Also, after my exams were over that was the only time I didn't spew.

At the time when Isabelle discovered that she was pregnant, she viewed the pregnancy simply as a cluster of cells. Viewing it in this scientific sense encouraged her to pursue the termination and helped post-termination as well:

I remember going through the ultrasound and knowing that it had a heartbeat and that kind of threw me a bit. But after a bit of time I realized that scientifically cells are alive and that explains the heartbeat.

The decision-making process involved consideration of the advantages and disadvantages of continuing with the pregnancy. In terms of disadvantages, Isabelle was a first year University student and financially not in a position to support a child. Isabelle knew that she was eligible for Government assistance but realised there were so many other obstacles in the pathway to becoming a mother such as not having a driver's license, and not being in a long-term established relationship. Her boyfriend attempted to problem-solve with her and suggested that they could get married. However, Isabelle did not want the pregnancy to be the main reason for marriage:

I just thought oh I don't know if I want to be puking up the isle of the registry office. Like that's not right – I never wanted a marriage of convenience.

Isabelle's decision-making did not consider adoption because she had some knowledge of how New Zealand adoption system process worked. Isabelle was, and still is, a regular newsreader and so was aware of the emphasis on the open contact between adopted child and biological mother. Isabelle also was uncertain about the time between birth and when she would have to sign the legal documents to accord all rights to the adopted parents. In this sense, Isabelle felt that her emotions would be very powerful and she would not want to let the adopted parents should she change her mind:

Is it fair to the adopted parents, you're not my real mum or father and the cooling off process to change your mind. I don't trust myself to not turn around and be like well actually, change my mind sorry I want to keep it. Thinking about how the biological mum and the adopted mum works together, I don't know how it really works in a way that benefits the child.

The weight of the decision-making became extremely stressful and emotional for Isabelle. Being in this situation was never contemplated as part of Isabelle's life course and so much of the initial stages of decision-making concerned not wanting to be in the situation in the first place. Isabelle experienced some initial denial and wished that time could freeze as the gravity of the decision became much more difficult than she envisaged:

I think that needs to be said to some people. Sure you could be flippant about it beforehand but when you are in that moment it actually isn't as easy as you think. You have so many different factors to weigh up and it's not like a drive through.

Time pressure was a factor that complicated decision-making for Isabelle. Knowing that she had to make a decision soon, and being reminded by health professionals and counsellors, led to increased stress. This combined with the knowledge this decision was a significant one in her life, resulted in mixed emotions in the period leading up to the termination.

Intimate relationship education.

When Isabelle was at secondary school she received only a very basic level of education about sexuality and relationships. Her education was centered mainly on contraception and there was a degree of bias about how education was disseminated. Having had no education on forming, maintaining, and the various complexities of intimate relationships meant that Isabelle undertook a ‘trial and error’ approach. Practically, this meant that Isabelle interacted with different people in the hope of realising what she did and did not like. When at high school, her education emphasised abstinence:

I know that we covered the basics of contraception but I don't think we did cover relationships. I remember we had this awful abstinence only group that came in and talked to us. Our health teacher was really pissed off and really she should have put a stop to it. It was so inappropriate and I guess our teacher didn't realise beforehand. It was horrible they would ask us why do we have sex? And someone would say because it is fun. They would then get us to think of other things that we could do for fun instead. It was bad.

Isabelle is comfortable talking about contraception options and had no hesitation in making an appointment with a health professional to discuss this. Moreover, as Isabelle had a background in the health science field, she learnt about contraception and termination procedures. Isabelle was surprised to learn how quickly terminations were addressed in her study and disappointed that the nursing profession downplayed their significant role in the termination process. Prior to this, Isabelle had to undertake her own research into pregnancy options because this was not discussed during her schooling:

It was literally like a 10-minute lesson. It is a common medical procedure – 1 in 3 women or 1 and 4 don't quote me on the stats. There are nurses who are anti-abortion and this lesson could have been the opportunity to provide more comprehensive education. Even my tutor who was pro-life explained abortions as being from the time you know you are pregnant until partial life or live abortions. Anyway I can't quote remember the

exact term she used. But the way she explained it, it was such a politicized term.

Intimate relationship with termination partner.

Isabelle's boyfriend (Henry) with whom she later became pregnant, was her first proper relationship. This also was her boyfriend's first proper relationship. Although she had had a couple of brief relationships during secondary school, Isabelle felt there was no spark with these earlier relationships. Isabelle and her boyfriend met in their last year at secondary school and were together for four to five months before the pregnancy was discovered. Whilst they lived apart – a 90-minute drive away - they still managed to see each other every weekend.

From the couple of relatively brief relationship experienced during her high-school years Isabelle discovered qualities and desires for future intimate relationships. She wanted an equal relationship where there were no power imbalances as well as a loyal and trustworthy partner. Having a romantic element and 'chemistry' was also important, along with genuine commitment in that relationship:

*I used to have a boyfriend who was still in love with one of his friends.
Like why do you do that?*

Isabelle and Henry had the same friendship group during high school and met at a party. Over the course of a year their friendship strengthened, became more playful, and they both demonstrated loyalty to one another. They also became good supports for one another when either experienced difficult and stressful life events. Whilst they both started unconsciously to develop feelings for each other, their own relationships deteriorated. It was around the time of New Years Eve that their feelings for one another became heightened:

We were both quite shy so it took some time before we told each other how we felt.

When they first met, Isabelle had a good first impression of Henry. She perceived him as being very kind and fun to be around. After a few of her friends started to speak very highly of him, Isabelle initially brushed this off because although she felt that he was a genuinely nice guy, he was a little bit immature. As they lived in separate towns, there was a period where they lost contact. However, some time later they encountered each other at a mutual friend's party and Isabelle found Henry to be more attractive, and found his kindness particularly attractive:

You get to a stage where you think, you know the nice guys are the ones who are worth it.

Because they were good friends before commencing an intimate relationship, they had a solid foundation where intimacy further strengthened their connection. By supporting one another during rough patches in their life, there was a high degree of trust in their relationship. Therefore, neither felt that they could nor should hide any aspects of their lives. This allowed their relationship to start without any desperation to impress one another:

I think it helps to be friends first. As soon as that romantic part come in you do learn more about someone but yeah.... It helped to share things about ourselves while we were in a friends basis. Like we were a lot less vulnerable that way.

Being in a communicative relationship was a further important characteristic. Isabelle perceives relationships and life as having its inevitable 'ups and downs'. In this sense, a relationship and resiliencies can be tested where individuals can quickly learn new traits about their partner. Being able to communicate ensures commitment to the relationship and the potential for relationship growth.

Subsequent relationships post-termination.

Following the termination, Isabelle and her boyfriend tended not to dwell on this experience. There was the odd occasion that they would try to see some sort of humour out of it as a way of coping. However, due to the stressful start to their

relationship, they wanted to focus their efforts on trying to be a 'normal' young couple:

Like he never used it against me. I think that is what he wanted to happen (terminate) but he was nice enough not to, you know, put any kind of pressure on me. I guess he got caught up in the emotions of it. He is quite a sensitive wee boy.

Isabelle did not witness her partner being emotional about the termination. As they were in a long distance relationship they tried to focus on spending their weekends together, being positive, and having quality time together. As time progressed, the different emotions regarding the termination began to create a sense of personal and emotional isolation:

I think in some ways that upset me more (partner not being emotional). Like what the hell here I am processing this after the fact and you have just moved on. That did cause a little bit of resentment. Because you know on the day he was like oh how horrible but then after you know suddenly it was my own journey again. So yeah that was hard.

Following the termination, Isabelle experienced raw and intense emotions and she experienced difficulty in sleeping. For a period in time, she felt a level of resentment and frustration towards her partner for being emotional at the hospital. Following the termination, Isabelle noticed that her partner appeared to be coping remarkably well whereas Isabelle continued to experience a sense of isolation:

He did not have to go through it like I did so I guess in some ways he was a bit of an outsider. For a while I did think it was shared but later on it was clear that I was really on my own, it was a big thing to carry.

The way Isabelle coped post-termination was in part related to her then sense of self-responsibility. Women inherently are seen as the ones who make the ultimate decision and therefore they are the ones that 'should' carry the majority of any emotional 'load'. As this was not shared, Isabelle strived to preserve her sense of

independence and hide her emotions. Isabelle felt as though her emotions might be off-putting for her boyfriend and endeavoured to conceal this from him:

The way we coped with it was very internal. In some ways I guess you know as women we carry 'the problem'. I guess in some ways we were in a very new relationship I wanted to hide me at my worst. I am an emotional person.

Isabelle also was caught also between feeling intense emotions regarding the termination and emotions surrounding her partner's ability to move forward. She knew that trying to elicit her partner's feelings was unfair, even though it added towards her isolation in the aftermath of the termination. There was initial confusion and tension between her partner having being present at the termination and therefore having 'shared' that experience, and her partner subsequently being able to move forward with ease:

It is unfair to expect him to be just like me. You can't force something that is not there and I can't make my problem of him moving on so fast – his problem.

Given the stress involved in decision-making, Isabelle was surprised that their relationship survived the termination. The novelty of the relationship meant there was less of an emotional obligation between one another and this could be expected to deteriorate following a stressful experience. Moreover, the pressures of knowing how a new relationship 'should' look for their age group might also have contributed to negative expectations about the longevity of their relationship. The reality that their relationship persisted was a surprise and for Isabelle and one that she viewed positively:

I didn't see how we could survive something so big and we were in such an infant stage. I don't know why I thought that (relationship not surviving). Maybe it was the media or my own mind...I was kind of expecting that when I ended the pregnancy, our relationship would then end too. I guess our relationship was early enough, I've sometimes

thought about this, like we were early on in our relationship that we could take the stress. Whereas if it was much later, if we had been together say a year it might have gone the other way (relationship ending).

Following the termination, they learnt to always have each others' best interests at heart. In many ways, the experience of a pregnancy termination marked the start of a deeper and more mature relationship, beyond the length of time they had been together. Their relationship essentially missed the initial 'honeymoon' phase that most relationships progress begin with and progress from. This led them to experience a deep connection and maturity in their relationship at a relatively early stage:

Being so early on in our relationship it forced us to grow up really quickly. It just took us to a new relationship – more serious and mature and it was premature. I feel robbed of that time, you know that honeymoon phase.

As it stands, their relationship has progressed to a stage where they are comfortable being themselves and both are able to retain intimacy without discussing that significant moment of their lives:

But he is still a really lovely person. There are times when he plays on my insecurities but it's not like an abusive relationship whatsoever. No gaslighting (mental abuse where information is distorted). But yeah he does play on my insecurities but then again I'm the dominant bitchy one in the relationship. It is probably him just hitting his balls back when he can.

Case study Five: Rachel

Life before falling pregnant.

Rachel is a New Zealand European who spent most of her childhood in the central North Island. Rachel was younger than most when she started university as she had skipped a school year previously whilst at high school. Going to university,

Rachel had low confidence and struggled to adapt to University life as she lived away from home and had new pressures associated with attending university. Getting an education and going to university was an expectation from Rachel's family:

There's a whole heap of pressure from my family to go to University and to have a defined trajectory.

Rachel's older brother had a defined trajectory, was very ambitious, and worked in the commerce field, a dream he had had since his years at intermediate school. He was traditional regarding getting married and then, at a suitable time, travelling and having children. Rachel notes that her brother followed what Pakeha society would frequently regard as being 'normal':

He followed the norm, even though it isn't really the norm and when you look at it statistically it isn't the norm but ideally – it's what you are meant to do.

Rachel was unsure what she wanted to do for a career whilst studying at university. She enjoyed studying a range of subjects, including mathematics, and earth sciences, psychology, and other social sciences. Rachel performed well in most of these areas and ended up pursuing a career in social services because she found this interesting. Rachel received family pressure about suitable career paths and frequently was criticised for choosing career paths that were not prosperous financially. One thing that remained constant throughout Rachel's progression into adulthood was the certainty of not wanting to have children. During her years at University she felt as though she received no guidance from lecturers which left her in limbo about what to do once she had finished her undergraduate degree.

Rachel experienced trauma in her childhood, which later infiltrated into subsequent initial intimate relationships. Her first experience with an intimate partner was in her first year at university and was more of a mutual 'crush' rather than intimate relationship. On one occasion when Rachel was about to get

intimate for the first time, she informed her partner about the abuse history she had endured. This led the man instantly to retreat, telling Rachel that “*I can’t do this. You’re going to have to leave now*”.

Throughout this time, Rachel was experiencing difficulties coping with her trauma. She was having suicidal thoughts and was admitted into Sunnyside Hospital twice. Although she found the hospital experience difficult, she acknowledged that her counsellors were reasonably good with giving her some hope for her future. However, given Rachel’s trauma history and presenting symptoms, she realises in hindsight that these counsellors were clearly “*out of their depth*”:

At that stage in my life, I was pretty messed up. It was an absolute lousy place, you got out as soon as you possibly could.

While staying at Sunnyside, Rachel was misdiagnosed with clinical depression. Subsequently, she was given a number of treatments designed to alleviate these depressive symptoms. Prozac was a commonly prescribed medication and the consensus amongst health professionals was that most people ‘came right’ after taking this medication. Some time later a psychiatrist then informed her that she had bipolar disorder. This misdiagnosis, and the delay in obtaining a correct diagnosis, was frustrating:

If you read my notes it constantly said mood instability, it was not depression. They made out like I was like making a choice not to be treated. I feel that my life would have been quite different if I had the right diagnosis and treatment a lot earlier on.

Rachel had attempted to enter the pregnancy termination service on two occasions, over a two-year period. The first attempt was unsuccessful due to the difficulty in ‘getting a foot in the door’ owing to her mental health issues. This resulted in her son being born. On the second occasion Rachel entered the termination service and was able to receive a termination.

Culture and religion

Whilst at intermediate school, Rachel remembers identifying with feminist philosophies and pro-choice movements. On one occasion, Rachel advised a Māori teacher about the option of termination, after she learned that her teacher had five or six children. Rachel was brought up with the perception where different ethnicities were viewed as being equally capable and intelligent. In this instance, regardless of ethnicity, her family viewed everyone as being able to perform at a high level educationally. Through her own personal experience she also was aware of, and sensitive to, gendered based discrimination. However, at such a young age, Rachel acknowledges not being aware of different attitudes to reproduction because she had not been exposed to these. In her family, because there was not much external socialisation, Rachel was not exposed to a variety of opinions, and had no knowledge that reproduction or termination was a sensitive topic. When reflecting back on her encounter with her teacher, Rachel tried to understand the actions she took that day:

I don't know what made me do it... I really don't... all I remember was being very concerned about her well-being. I suppose I just really wanted to make sure that she knew which sounds really silly. She had children you know within one year between them and I just couldn't get my head around that. Obviously now I understand it in terms of individual choice and you know background and other factors. Of course she was very offended by it. Looking back it's like oh my god.

Rachel learnt about intimate relationships through her friends and from reading a variety of books. Rachel particularly enjoyed reading the works of feminist scholars and philosophers, and she carried these ideas into her future intimate relationships. Rachel liked the empowerment that these scholars championed and this resonated with ideas concerning 'choices' rather than 'social expectations':

At the time I was reading things like Simone de Beauvoir and studying women's studies. I was questioning social ideas, women's roles and all those sorts of things. I had a strong analysis of sexism and feminisim. That probably factored into how I perceived relationships - like you had the

right to choose how you interacted in a relationship. I wanted to be able to make those choices you know, rather than follow what was seen as ideal.

When Rachel informed her family that she did not want children they interpreted this as something that would change as she got older. Rachel was well aware of the view that not having children meant that you were physically unable to:

They just thought I'd grow out of it...like my sister. People say oh you might have some biological clock thing happen and I'm thinking yeah right. People still haven't totally accepted the fact that she doesn't want children... Sometimes people think that if you are of a certain age and don't have children they then go to this place of you might not have had children cause you couldn't have children.

Discovering pregnancy.

On the first occasion, when Rachel discovered that she was pregnant she was in denial because she had visited her doctor owing to her feeling unwell generally. Despite her denial Rachel knew the decision she was going to make:

I didn't believe there was a chance in hell that I could've been pregnant. I knew immediately that I didn't want it. To be honest I was a bit pissed off that it didn't work. It's not like the pill where you can forget to take it. The IUD is always there; well as long as the string is there you know it is there.

Rachel had to pressure doctors to get them to agree to fitting an IUD because (albeit small) there was an increased risk of developing a pelvic infection that might effect fertility. Rachel reasoned that in fact the doctor was reluctant his was hypothesised as creating the doctor's reluctance to fit an IUD in a young woman who had never had children. There were many doctors at the time who did not want to fit an IUD and so she had to go to Family Planning to obtain one. Family Planning left the decision-making to Rachel as the 'client' and when they were sure that she understood the risks, they agreed to fit the IUD.

Upon assessing the termination service for the second time accessing the termination service, Rachel had a strong suspicion that she was pregnant. Having been a patient with this doctor, meant that her doctor was aware of Rachel's contraception and her views on future pregnancies. Rachel was not required to explain her circumstances in detail and did not worry about the doctor's decision to refer owing to this already positive doctor-patient relationship:

I did find my doctor supportive about the whole thing. She understood that I didn't want to be conceiving at the time. She knew I wanted to be in a sexual relationship which she had no problems with. She did her best to make sure I didn't end up in that situation. Because I had that relationship with that doctor too that was probably a good thing. So I think because of that partly she really did everything she could do to get the process going and make it as hassle-free as possible.

Despite having initiated a break-up with her then partner, James, Rachel decided to inform him of decision to terminate. She expected James to react with anger – and he did – and he tried to persuade Rachel to agree to adoption. Because James had been adopted out as a child himself he thought that by adopting the baby, he and Rachel could then resume their intimate relationship and not resort to termination, which he adamantly opposed. Although James was anti-termination at no time did he attempt to stop Rachel from having a termination:

I thought he was a complete and utter idiot. I had made it very clear that our relationship was very much over. I can kind of understand the abortion thing because he was adopted, but we had those conversations (about termination). He just nodded his head and said yeah yeah probably thought that the likelihood of this happening was practically non-existent.

Intimate relationship with termination partner.

In terms of relationships, Rachel described herself as having many (10 to 12) relationships during the four years she was at university. Other students would have viewed this as a large number, but compared with her friends, this was not

sizeable. Moreover, during her university years, Rachel had a very active social life where she had many friends from different backgrounds:

I also lived in a hippy flat which was laid back and what you did was your business but I also had more traditional friends too.

At the outset of each relationship, Rachel warned each partner that should she become pregnant then she would choose termination. Being honest about her views on termination provided each partner with the opportunity to leave if they had strongly opposing beliefs. For Rachel having this conversation was similar to discussing contraception. Rachel was always very careful when it came to managing her sexual health and always got sexual health check-ups. At that time, there was the AIDS epidemic so sexual health was uppermost in many people's minds so it was a very important and easy conversation to have with sexual partners. However, after her second brief hospitalisation, Rachel discovered she was pregnant to a man who she had been with only briefly:

We were in a relationship but it was kind of like a fling – lasted one or two months maximum.

The relationship that Rachel had with James was in the dating stages. It was at the beginning of what could have been a successful relationship. They met when they were doing volunteer work, and there was an instant attraction between them:

It was one of the only times in my life where I have had the whole you look across the room and you go wow and there are sparks. There is all this chemistry. We then started spending time together then I thought actually this guy... he had very limited capacity for role reversal and very self-involved.

After Rachel and James began to spend more time together she became quite disappointed with their relationship because it was centered primarily on events that happen in James's life without considering Rachel. This made the progression of their relationship difficult as relationships are most satisfying when there is a

balance of expectations and a sense of equality. Rachel felt increasingly dissatisfied with the relationship due to the self-absorption and sensed that it was not going anywhere. She decided to end their relationship, after they were together for two or three months. It was after they had broken up that Rachel discovered she was pregnant:

I was very much of the opinion that we needed to cut our losses and move on. There was no hope for us and I was happy with that decision, it felt right.

It was around this time that her boyfriend mentioned he was beginning to develop feelings for her. Their relationship had been ‘on and off’ while Rachel was at university and they mutually agreed to maintaining an ‘open relationship’. Rachel was the only girl that her boyfriend had been with as he was focused on completing university:

If I was describe him – well, he was a bit of a nerd and so he didn’t meet many women. He had a fling with someone else and I don’t know why but this really annoyed me, which makes no sense.

They argued about this and James reaffirmed that he wanted to continue with their relationship. They remained together in a long distance relationship and then both moved to the central North Island to undertake postgraduate study. Their relationship lasted roughly two years.

Intimate relationship education.

Rachel and James had discussions about contraception and agreed that Rachel would have an Inter Uterine Device (IUD). They also discussed what would happen should Rachel become pregnant. James appeared to be satisfied with the decision to terminate. When Rachel was at secondary school either they did not cover contraception during class or she missed that class. However, Rachel did not hear anyone at school discussing it which led her to believe that it was not covered. At intermediate school, she learnt about puberty and the menstrual cycle

but additional information was not provided. During secondary school there also were no guidelines around forming and maintaining a relationship. Looking back, Rachel notes the irony of this:

We had a subject called home economics where we had to cook and everything. But we also learnt how to put on a baby's nappy and how to make a baby bed. It was either in 3rd or 4th form. I think it was almost like a subject of what you do as a housewife like how often you wash your socks and underwear.

Growing up in a relatively low income area of the Central North Island, Rachel noticed how these demographics might have influenced her education regarding sexual health and intimate relationships. Furthermore, the context of that era was rather traditional where it was assumed that women would marry and then learn about relationships once they were in one - a sort of 'learning on the job', apprenticeship approach. It also was an era where women's role was to cook, clean, and look after children.

Subsequent relationships post-termination.

In terms of the effects a termination might have had on subsequent relationships, Rachel was adamant that having open conversations about the possibility of termination was the only correct strategy for her. The importance of having her partner's approval of a termination was important for intimacy in her relationship. Having fallen pregnant, by contraceptive failure previously, as well as still being fertile, only served to reinforce the importance of these honest conversations for Rachel:

If I knew that he was really anti-termination then I would feel a bit uncomfortable about having sex. So yeah people need to know that, there is no way in hell I am having another one, no way. Basically saying if you don't agree with me doing that (termination) then don't go there (have a sexual relationship with me). I mean I would do everything to not get pregnant because I don't want a termination. But if contraception fails then that's what I would do.

Whilst Rachel sees the value in having conversations concerning terminations, she acknowledges that it is a source of mild anxiety because she wants to protect her son from this knowledge. Rachel was attempting to weigh up the consequences of her son finding out against the need to have open and deliberate conversations in order to be prepared for any unwanted pregnancy in the future. Rachel is comfortable having her son know that he was an ‘accident’, but still does not want him knowing the truth behind this, as a way of protecting his feelings:

Like he knows that he is loved but he knows that he was an accident. It is better to know now than to ask a whole lot of strange questions.

Other ways in which the experience of a termination can manifest itself is through a heightened sense of vigilance about the possibility of pregnancy despite being on reliable and effective contraception.

I do (feel nervous). Partly because my menstrual cycle has come back really regular now. So in terms of fertility it tends to suggest that I am ovulating regularly so you know.... There is a little bit of me that pays attention and keeps tracks of when my periods are.

In some ways, by not being religious and therefore seeking out a like-minded partner, this most likely has removed the possibility of competing incongruent views regarding terminations. In some situations where Rachel has not spoken of her experience, she has used her partner’s religious views as a general gauge on terminations. However, she still has hypothetical conversations around falling pregnant and then choosing termination:

In some ways it is made easy because I’m not religious and most my friends have been atheists or skeptical and a lot of people that I know who have been anti-termination are religious. People who are more towards the atheist side aren’t really. But of course there are those that don’t like it. But there is often a religious element that runs through it.

Case study Six: Megan

Life before falling pregnant.

Megan grew up in the upper North Island with a family who had a strong history and background in agricultural. Megan lived with her mother as her siblings were studying at different tertiary providers in New Zealand. Megan also was in a long-term and long-distance relationship with her partner whereby her and her partner who lived in a different part of New Zealand. Megan was completing her undergraduate degree through correspondence and also was an emotional support person for her mother as her parents were then in the process of separating:

It was a really stressful time. My parents owned a business and dad took off with all of the money from the business. Mum was quite clearly depressed, going through a roller coaster of emotions and so I was her support because my siblings were not living at home.

Culture and religion.

Although, Megan grew up in a relatively religious household where they share spiritual views, she identifies as being agnostic. Her family were never avid church attendees, but Megan did attend an Anglican secondary school and was baptised. While Megan believes that something spiritual is ‘there’ she is yet to discover what this means for her:

I do understand the bible, having read it, and I can understand different religions and things. For me whilst there is something up there or out there I don't necessarily believe that God is the best way to describe this – that's just my point of view. I do think there is a lot we can take from it but not that it is the be all end all.

In terms of reconciling the termination with her spiritual views Megan acknowledges the conflict between the two and felt that speaking with a church leader would not in anyway be helpful to her:

In some ways and this is probably being a bit sarcastic but for some people religion can be a crutch, an opportunity to lean on a higher being. When you are going through a rough time you can talk to someone else and they completely understand. I kind of wish in some ways that there was that opportunity to have that connection with something.

Discovering pregnancy.

Megan discovered her pregnancy when having a routine smear test. Megan had missed her period due to the stressful circumstances in her home-life and interpreted this simply as being an ‘off’ month. However, when she went to receive the smear results the nurse also performed a routine pregnancy test. Upon being informed that the test was positive for pregnancy Megan instantly decided that she did not want this child. When rationalizing why this was so, values of independence and practicalities were referred to. Megan regards herself to be independent, and because of her parents’ separation, she saw first-hand the perils of being reliant on other people. Megan reasoned that in order to have this child, she would have to rely on her boyfriend who lived in a different part of the country and he would need to travel frequently. Megan felt this to be impractical along with the demands and responsibility of raising a child.

Megan spoke with her local family doctor who knew her family’s situation regarding her parents separation who did part-time work in sexual health clinics. Megan felt comfortable approaching her doctor to raise this topic. Megan’s doctor advised her to wait for one week to decide what path she wanted to pursue and then, if she was sure, then she would refer her for termination. Although Megan sensed her doctor’s disappointment that she had chosen the termination path she related this to the fact that her doctor already had three children. In hindsight, Megan was grateful that her doctor made sure that she had time to arrive at her decision:

She has got 3 kids of her own so I guess she would have been the first person to be like oh my god congratulations. So for her it wasn’t like it was a bad thing but she definitely fleshed out my decision-making and made sure I was making the right choice.

Megan discussed her options and preference for termination with her mother. It was at this moment that her mother confided that she had previously had a termination herself. This came as a total surprise to Megan, although it did not change her preference for termination. Megan's mother spoke about her reasons for the termination - the aversive side effects of the medication that she was on - and reiterated to Megan that she had to be certain about her decision:

My mum said that she could understand what I was going through. She did say that if she was me she would not choose to terminate and said that I will regret it. However she did say that it was my choice but kind of tried to warn me off at the same time.

Megan was not affected personally by the possibility of regret as she thought that it was her choice and that she would be able to 'deal with it' later, if it were to arise in the future. Megan noticed the similarity in coping styles between herself and her mother:

I guess my mum is a bit like me – puts everything into a box and puts it to the side in order to try and move on. For us it does work for some time to do that.

Megan's then boyfriend (Oliver) had stayed with her at her home on a few occasions following the discovering of her pregnancy. They discussed the pregnancy and Megan reaffirmed to him the importance of being open with her in terms of how he felt about termination. Megan also mentioned that couples counselling was an option for them if he boyfriend was unsure about it. However, throughout this time her boyfriend did not express any opposition to the idea of termination. In the lead-up to the termination, having earlier had a conversation with Oliver about her pregnancy, Megan was content that he had left the decision largely up to her. As the six weeks had elapsed from the discovery of pregnancy to the termination, both Oliver and Megan both expressed similar views regarding the pregnancy:

Together we talked about the baby and how it was more than a cluster of cells.

Oliver had previously participated in martial arts as a hobby and this led to an accident where he was kicked in the groin. Subsequently he was informed that it was uncertain whether he would be able to have father a child. Therefore, when Megan discovered that she was pregnant, Oliver was excited:

He was like yeah it's your choice but at the same time he was ecstatic. So for him that was quite a big deal.

Megan was quite nervous about telling Oliver as she did not know how he would react. She was surprised that he appeared rather content and that he expressed indifference regarding her decision to pursue termination:

He was probably a bit disappointed that I didn't keep it but he didn't outright say no to me not keeping it.

Intimate relationship with pregnancy termination partner.

Megan and Oliver met when her friends sent a dating profile to the local radio station. From this, Oliver obtained Megan's mobile phone number and after contacting her they began dating. Although they lived in separate cities, problem-solving as to how they could eventually be together resolved this geographical distance:

He seemed like a really nice guy. I liked him. I didn't have any reservations about him. The only red flag was the long distance thing. For me to get over long distance is to plan how we are going to plan being together.

Oliver was very considerate and for Megan it was important that he fitted in well with her family. He always prioritized Megan and liked to spoil her when he had the money to do so. Their relationship, Megan believed was very fulfilling:

He definitely put me first in that relationship and it was nice to be made a big deal of. He was everything that you aspire to have in a relationship aside from him having issues with talking about the past.

As Megan and Oliver had a strong relationship - at least initially and prior to the termination - it surprised Megan how he handled such a stressful situation. Prior to this experience Megan had not witnessed how he handled stressful situations and linked this to the emotional composure and obedience that was a necessity in his workplace. However, she soon saw a different side of him in a way that she found very unattractive, if not worrying:

He never seemed like a throw your toys out of the cot person. He seemed very level headed. I had never seen his anger issues before the termination. It was shocking and it was annoying like you can be angry about something but there has to be a limit. I guess I had never seen that selfish side of him before and that took the rose-tinted glasses off a bit.

Oliver liked being in charge of the relationship, something that Megan did not mind. While their relationship was not characterized by frequent arguments, the only time they did argue was when previous boyfriends were brought into the conversation. Megan did not know how to handle Oliver's fixation on her previous boyfriends and she perceived his behaviour as immature:

I would only bring it up if it was appropriate to the situation like hey I didn't like this happening in my previous relationship can we not do this in our relationship. It just got really awkward and I would try avoid the stuff that would set him off.

They had been in a relationship for one year prior to the termination. In the two months before the termination cracks began forming in their relationship and the 'honeymoon' phase ended abruptly. Megan felt that having a long distance relationship might have contributed to the 'spark' lasting longer than aif they had sustained a face-to-face relationship. It also meant that they were not able to see one another in stressful and daily activities:

I guess it takes a while for someone to show their true colours. I guess you make a lot of effort in the first part of the relationship.

Intimate relationship post-termination.

Following the termination Megan was offered, but rejected, counseling because her emotional resources had been depleted by Oliver. On occasions Megan suggested joint counselling to her partner but he refused on the grounds of confidentiality – he did not want these counseling sessions to appear on his record. After trying to support both herself and her boyfriend emotionally, Megan discovered that her boyfriend had not been honest in communicating his feelings prior to her termination:

He blamed himself for not being true to his feelings – that he wanted me to keep it. He would say if only we had not had the termination; we would be happy. Our relationship broke down afterwards quite quickly. Our relationship was all over the place, things had fundamentally changed.

As their relationship began to deteriorate, Oliver's behaviour and threats towards Megan worsened. Oliver threatened Megan's acquaintances and on many occasions threatened to take his own life. Megan remembers one instance where Oliver commented that he would "kill a guy and you if you ever got with anyone else". This escalation of behaviour led Megan to end her relationship with Oliver.

The process of breaking up with Oliver took six weeks, involving many telephone calls where Megan explained why they had broken up. It progressed to the stage where Oliver did not accept the break-up and demanded that Megan tell him face-to-face. When Megan met Oliver he stated that there was no point in living without her and explicitly linked this to the termination and his subsequent regret. Oliver repeatedly stated that he should have "dug his toes in and stopped her" Megan had experienced emotional blackmail before but not to this extent and she felt ill-equipped as to what to do. As Oliver tried to induce guilt in Megan, it became very clear that Megan needed break up immediately:

He said you know you can't break up with me we had gone through all of this stuff. I can't live without you. It was heading towards threatening to commit suicide. It was a bit of a guilt trip. But for me the best way to move on was to start with a clean slate and so I couldn't do that with him (Oliver).

That same night of their break-up, Megan discovered a voice message from Oliver. This message said that he was at the beach and was going to commit suicide. Megan quickly telephoned the crisis team at the local hospital as well as the police. This was a stressful time for her, one that understandably evoked many intense emotions:

The police said they couldn't see his car at his parents. They couldn't find him at the beach and it was starting to get very serious. The police had also spoken to the parents and they didn't know where he was. He then did not show up to work which was very serious – he could be court marshaled for not showing up... No one knew where he was... I was so worried. I still cared for him.

When Oliver was found, he was then required to undergo compulsory assessment treatment at the local District Health Board. This was a difficult time for Megan as she was unsure what to do; she wanted to know that he was safe and looked after but also did not want him to deteriorate mentally and emotionally.

Subsequent relationships post-termination.

Megan felt that following her termination, she was more sensitive to any conversations that involved having children. Having been through that experience, the concept of having children at some time in the future became much more centered on the present. The line between the present day and dreaming about and planning one's future quickly blurred:

When those conversations of having kids do come up I feel quite hyper-aware. Like it is a lot more real. I guess having been faced with the reality of it it's not so impossible.

Megan acknowledges that her desire to have children has strengthened, and that her and her new partner (Zach) have discussed this in detail. Megan raised this relatively early in her relationship with Zach because having had a termination Megan felt a greater sense of reality about the possibility for pregnancy. Since her termination, Megan feels much better informed for when she decides to have a child and notices that missing her partner is often a trigger for wanting to start a family:

I guess it is a knee jerk reaction like if I miss him I want everything now. Because you don't get to spend time with them. But you know... I am quite an impatient person.

Megan sees herself as being more tolerant in her current relationship than before. Megan once had preconceived ideas of the qualities she wanted in a partner and interests that she would like her 'ideal partner' to have. This included getting along well her family and, in particular, her mother. Megan noticed that she made more sacrifices, following the relationship deterioration with her former partner, Oliver. For Megan, the 'bigger picture' issues became more important than small preferences, an outcome that she attributes to having had a partner who was not supportive following her termination:

You know for our first date we went and watched a game of cricket. That is something I am so not a fan of (laughs). I can't stand watching my brother and sister play sport.

Following her termination, Megan's desire and appreciation for independence strengthened. This has presented Megan and Zach with some issues in their relationship, as they have had to reconcile different lifestyles and preferences. On occasions, this has proven to be difficult given that they found themselves in a long-distance relationship:

So the relationship was a bit strained. We try and see each other every six weeks otherwise cracks start to show... I am quite an independent person and I am not very good at checking in with how he feels with a lot of

things. I quite like me doing my stuff and having the freedom to come and go as I please.

In order to deal with this, Megan and Zach have agreed to have ‘me’ time when eventually they live together. On the odd weekend she would encourage him to spend time with his friends or take up a hobby. Megan believes they would appreciate each other more and that it would add a further level of intimacy through curiosity:

So he has something else going on and the attention isn't just on our relationship. It is also I guess something else to talk about.

Megan acknowledges that long-distance relationships can help to keep the romance more alive, and in some ways the relationship becomes more meaningful and appreciated. Megan noticed that when she and Zach spent more time together they would tend to watch movies and their conversations and interactions decreased. Conversely, in a long distance relationship, intimacy was strengthened:

Long distance relationships make you dig deeper. You don't have the choice of sitting there watching a movie and not really saying too much. I guess... with my current partner I bought this book about questions to ask each other and if we get to a bit where we run out of things to talk about I bring the book out. It stimulates those conversations that you wouldn't necessarily think of and it stops you making assumptions about people. You move past the how was your day at work.

Chapter summary

This chapter presents six case studies about the lives of women and their intimate relationships both at the time of termination and post-termination. This chapter also has examined participants’ perceived preparedness and confidence in navigating intimate relationships. Attention to important social contextual factors – for example, culture and religion - have also featured in the participants’ narratives.

The following chapter, Chapter Five, continues the participant's narratives concerning the sphere of quality of care. For some participants, quality of care was influenced by intimate relationships that in turn, contributed towards either a positive or negative overall experience of young women's pregnancy terminations.

Chapter Five: Participant narratives – Quality of care

This chapter predominately examines participants' narratives regarding their experience of quality of care in New Zealand pregnancy termination settings. Quality of care includes clinical components such as procedure effectiveness, reminding women of alternative options, and interpersonal components including tact, empathy, and being non-judgemental. Quality of care also refers to accessibility in terms of cost, geographical location, timeliness of the service, and the ability to arrange childcare or time off from work. Within this section, advice for young women considering a pregnancy termination has also been included. As the following narratives will demonstrate, quality of care has a profound impact on women's overall experience of pregnancy terminations.

Case study One: Jenny

Partner presence at termination setting.

Jenny attended the first few appointments with the general practitioner, nurse, and later for the ultrasound by herself. Aidan declined to be a part of it because he was working and did not see any reason to be present with Jenny. This frustrated Jenny as at times it reinforced the highly individualised nature of the experience:

Aidan never came with me. Not because I didn't want him there. I mean it was his doing that got us here. But he just showed no interest – there was always an excuse. He kind of made me feel like a child by saying that surely I was able to go alone and that it would be embarrassing for him.

Accessibility.

As Jenny lived on the West Coast of the South Island she was advised that she would have to travel to Christchurch for the procedure. Jenny was hesitant about this as she no longer owned a car and also did not want to be in the same town as her previous boyfriend, Harry. However, as she was beyond 10 weeks, she was required to have a surgical termination at Christchurch's Public Hospital. Because that hospital performed many terminations from both Canterbury and West Coast

areas, Jenny was required to wait four weeks from the time of her counselling appointment to the termination. She first entered the termination process at roughly five weeks gestation and so, in total, the process took six weeks from when Jenny discovered that she was pregnant to termination. However, appointments with doctors, the counsellor and the sonographer were organised relatively quickly, in fact within a matter of days. The greatest delay was with the procedure itself.

Jenny was nervous about being required to undergo surgery because she had not had surgery before. Her counsellor offered to accompany her and advised her that it was best to travel with someone. Jenny said that she did not want to go with anyone and the counsellor suggested that she could accompany her. In the end Jenny decided to go alone:

I just had a vision of the counsellor being there in the surgery room. To me, it is a private thing. I just thought I should get this done quickly and the less people that know about it the better.

Jenny borrowed Aidan's car and received \$100 in petrol vouchers from the counsellor, although she had to pay for accommodation whilst in Christchurch. As Jenny was sending half of her pay home to help her parents who recently had been made redundant, money was not easy to come by. Jenny therefore deferred the procedure for another week to allow her to have sufficient funds to have the procedure. Asked whether Aidan helped her financially, Jenny commented:

Aidan never really shared money with me. Like if we went out for a meal he would pay only his share and then look at me to pay the rest. He was a bit stingy looking back and I hated it.

Interaction with health professionals in the leadup to termination.

These first few appointments were difficult for Jenny as she felt guilty for the sexual experience she had with Aidan that had led this pregnancy. She found the doctor that she spoke with first to be quite abrasive. Because Jenny had never

talked to anyone about a termination most of her friends were religious – she had no knowledge of how to navigate the system. When Jenny went in to the after-hours doctor clinic she became anxious. She did not know whether she would be seeing a nurse or a doctor or what hoops she would need to jump through in order to obtain a termination:

The first guy I had just stared at me. It was really awkward. He told me that he could not help me and basically opened the door for me to get out. I cried as I walked to reception and then asked if I could speak to one of them in private.

This negative first experience lessened Jenny's confidence as she was already feeling guilty and embarrassed about having the procedure. However, the receptionist apologised and gave her a hug as she gave Jenny the names of doctors that she knew would be of help.

When it came time for Jenny to go for her ultrasound scan, she was very nervous. It was here that Jenny discovered her pregnancy was more advanced than she originally thought and therefore had to make a decision very quickly to maximise the chances of a complication-free procedure. Jenny remembers being in 'two minds' as to whether or not she wanted to look at the screen. However, shortly after the scan began she asked the sonographer if she could view the screen. The sonographer looked at Jenny and then turned the screen away from her. This led Jenny to feel very embarrassed and the atmosphere remained awkward and quiet:

I didn't want to fight it out – what's the use? It was a missed opportunity and yeah I do feel cheated by it. Looking back it wasn't her call to make. I know that now but at the time I was just so ashamed.

When Jenny went to her first pre-termination counselling session, she found her counsellor to be quite helpful. Sensing Jenny's ambivalence, her counsellor gave Jenny some resources to look at to help her arrive at a decision about the pregnancy. Jenny took these resources home and looked at them. Among the resources were exercised that imagined giving birth and how your life would

change as a result. Jenny mentioned to her counsellor that her family was Catholic and that she did not want them to find out. The counsellor assured her that everything was confidential. Jenny also expressed unease when discussing religion and whether she would be punished. Her counsellor advised her to ignore this and instead to think about herself and her future. Together they discussed in detail Jenny's relationship with Aidan and the counsellor reiterated the importance of Jenny making her own choice rather than to be influenced by others.

The counsellor then ran through the procedure in the hospital, advising her that she would be greeted at the reception and would be first in line that day. Jenny had many questions regarding the procedure as she had heard that terminations can lead to problems having children in the future. Her counsellor refuted this claim and stated that it was a tactic used by pro-life advocates and that she should not worry. The counsellor appeared to follow a schedule of questions that were put to Jenny and she used anatomical models to explain what the procedure entailed. A variety of strategies were used at this meeting:

She had these flashcards with different um weeks labelled for the different weeks. She picked up the one that was my number of weeks and said oh wait I shouldn't show you this and put it down. Towards the end it felt like a ticking box exercise... It wasn't really about me.

Jenny was embarrassed about being in this room with the counsellor and lacked the confidence to ask if she could see the flashcard. Jenny was curious and wanted to be aware of all of the facts before she made her difficult decision. Her sense of shame at finding herself in this situation undermined her confidence and so she tried to forget about the flashcards.

The counsellor asked Jenny if she was in an abusive relationship. Jenny replied that she was not and the counsellor explained that she had to ask because it was vitally important that Jenny's decision to terminate was her own decision. The counsellor also explained to Jenny what an abusive relationship looked like and while Jenny knew she was not in such a relationship, she nevertheless did feel that there was an absence of care on Aidan's behalf.

The day of the termination.

Jenny encountered a number of helpful staff members at hospital. Noticing that she was alone one of the nurses sat with Jenny when she started crying in the waiting room. The nurse talked through the decision-making process with her and reminded her that she had time to consider her decision. Unfortunately, this occurred in the main waiting room with other patients and Jenny was conscious that they were watching her and listening:

The nurse was trying to help but I was so embarrassed I just said yeah an mmm, I didn't want to be there, but I was, and it was my fault.

When Jenny was seen by the doctor who would be performing the procedure, she remembers feeling quite nervous. The doctor tried to make Jenny feel comfortable using humour and enquired about her future goals. He also discussed topical local news and events such as the 'Wellywood' sign. Jenny felt herself becoming more anxious as the doctor began to question her further about the decision:

He was saying hmmm and staring at me. It was so freaky. I thought oh crap he is going to say no, now what! I remember this voice in my head going for gods sake get a grip!

Jenny remembers that the waiting room itself was quite modern but had a 'sterile' feel to it. She noted that everyone else in the waiting room had someone with them and that the room was very quiet, with people looking at the ground despite the availability of magazines in the room. Jenny felt awkward because everyone seemed to be embarrassed and appeared uneasy when she accidentally made eye contact with others. Jenny felt that she was intruding into a very personal aspect of these womens' lives. Jenny watched as many women got up and left the waiting room to be seen by the doctor. She was surprised how quickly the women were being 'processed':

It was so fast. Like wow fast. It was like that the whole way through even with jumping between different providers there is no... continued care it was hard to get that real genuine caring feeling. I had to introduce myself

to so many randoms. Share my story time and time again. It was annoying and embarrassing.

The first doctor Jenny spoke with at the hospital, who put in the catheter, asked her if she was in a domestically abusive relationship. Having replied 'no' she was then required to sign forms to give consent to the procedure being performed on mental health grounds. Jenny noted that she must have looked confused but felt much better after the doctor had explained the situation:

The doctor said don't worry about this. It just means that you might be mentally effected if you had the child because you would be so stressed about this unplanned and unwanted pregnancy.

Quality of clinical care

Whilst talking to this doctor Jenny asked about complications arising from the procedure as she thought that her pregnancy was reasonably advanced. The doctor reassured her that he performed many terminations each day and that having a termination had fewer risks than giving birth. He showed Jenny the statistical data and this put Jenny's mind at rest knowing that only 1 out of every 1000 women might get a post-operative infection.

The procedure was both quick and painless, and a nurse held Jenny's hand throughout the procedure. After this, she was given a form that explained how to use the pill and what to do if you forgot to take the pill. The nurse asked her what contraception she was currently using and advised her to take the pill at the same time every day. Jenny was also made aware of the signs of an infection and what to do if this were to occur. When leaving the hospital, Jenny was ushered out the rear entrance because there were a number of protestors gathered at the front. Jenny felt safe as the nurse escorted her to her car:

Seeing them was quite confronting. There were so many of them, I saw some pretty disturbing pictures that really didn't make me feel good. In fact they are quite marked in my mind.

Advice for women considering a termination.

Jenny believes that support is vitally important when going through the various channels to receive a termination. Jenny went alone to the general practitioner, nurse, sonographer and then to Christchurch Hospital for the actual procedure which made the experience more stressful and heightened uncertainty:

All I wanted was someone to say you are doing the right thing and you wont be punished. God has forgiven you and you will not be punished. It was an emotional day – in some ways I really needed my mum. I have never wanted my mum with me so bad as that day but I knew she could never do that for me if she knew the truth.

Jenny also saw the value in visiting a family planning or sexual health clinic in order to start the process towards termination. She believed that these centres were more familiar with the procedures and would lead termination patients towards appropriate resources and supportive individuals:

Cause that's their job right... they are there to talk about things that other people would go tut tut about like sex and stds.

Case study Two: Keisha

Accessibility.

Keisha's cousin arranged the termination procedure including the various medical appointments: visits with General Practitioners, ultrasound and cervical smear, and the compulsory pre-termination counselling session. Her cousin informed her that the procedure in Dunedin was done under general anaesthetic whereas most other clinics in the North Island used local anaesthetic. As Keisha had to be in the North Island for the assault trial, (whereby her former partner alledged that Keisha physically abused him) she was not able to access the service until she was roughly three months pregnant. She decided on travelling to Dunedin, despite having to wait until the trial was finished. Being unfamiliar with surgery and hearing her cousin's negative experience of a local anaesthetic termination (where

she could hear and feel everything), Keisha opted for the general anaesthetic procedure in Dunedin. As her cousins had previously had terminations, they reassured her that the procedure was safe and supported her decision:

They were quite clued up they knew that in Auckland they just give you a mask whereas in Dunedin they knocked you out.

Keisha was very appreciative to her family for organising to repair the hole in the wall caused by Tucker. Her family also paid for her airline ticket to Dunedin and her cousin accompanied her to Dunedin for the procedure. There were therefore no barriers in terms of financial accessibility. For Keisha, a turning point had been revealed when she was able to see the disparity between her family's love for her and the so-called love her former partner claimed to have for her:

Seeing my family do this for me it was like the first time I realised how far I had taken myself out of that safe and protective environment.

Interaction with health professionals in the leadup to termination.

When attending the first compulsory counselling session, Keisha informed the counsellor of the abuse she had endured earlier with Tucker. The counsellor asked Keisha why she wanted a termination and allowed Keisha to do much of the talking, an approach that worked well for her. The counsellor produced a 3-D model of the uterus and explained to Keisha what the procedure involves. The risks associated with the procedure were not outlined, the anaesthetic procedure was not explained, and there was no visualisation of what the procedure for the day would look like:

I remember having a sore tongue after the procedure, I don't know why but it hurt for days afterwards. After the termination I was also bleeding quite badly, It was so weird it was like I had tried to bite it off. I also had this bright red chemical all down my legs which surprised me. I was a bit naïve, I felt violated although I don't know what I expected really. I thought I would wake up the way I went to sleep.

Having to walk into theatre herself also heightened her sense of what was to occur and remembered the stories that others had told her about their bad surgery experiences. This lack of 'walk through' information was evident when Keisha was surprised that she had to get herself on to the surgery bed. She was also not prepared that she had to take off her underwear herself and she felt uncomfortable doing this.

Despite having confided in a health professional about the abuse that Keisha had endured, the counsellor did not explore whether she was safe or give her other resources. Although Keisha was in Dunedin, away from the North Island, she was aware of the risk that her former partner might visit her hospital:

She didn't ask me if I was safe and links to other resources. Maybe it was because of the distance or she thought the police had it under control.

Keisha felt as though the counselling session was rehearsed because the counsellor worked her way through a series of questions relating to decision-making and present circumstances. Keisha gradually warmed to the counsellor as she let her do much of the talking and Keisha was very pleased to learn that she was open-minded and respectful of her decision. However, Keisha felt that the counselling session lacked a personal touch:

The weird thing about the counselling was we waited outside while someone else was in there. Then we were there and someone was waiting as we left. It just felt like a process. It didn't feel like it was case-specific.

The counsellor did not explore Keisha's identity with her culture and did not discuss her decision within either Māori or Samoan frameworks. Keisha was not asked for cultural preferences for the counselling session (such as karakia) and no Māori/Samoan concepts were used. However, this did not bother her as she was confident with the decision she had made which helped her to make the strange and unfamiliar environment more tolerable:

I think if people are swaying in their decision then including more culture stuff would be good – but not really for me.

Fortunately, the counsellor did discuss whether Keisha wanted the pregnancy remains so that it could be buried according to Māori custom. Keisha was pleased that this was mentioned, and after the session, she told her cousin about this. Her cousin told her not to worry and that she would organise the burial on her behalf. Keisha was unsure about whether there were any rules for the burial, and later became anxious because she thought that she would get in trouble with the law:

Cause we have to, it's not really an option for us. But I don't think we are supposed to bury it in a public place. I was relieved that I didn't have to think about burying it but I was paranoid for a long time afterwards that I would be sprung.

The day of the termination.

Keisha sat with her cousin in the waiting room where most young women were with their mothers. She remembers the environment being very quiet and the atmosphere tense. As her cousin had had a termination experience before, she emphasised to Keisha that today was a happy day and that she should be her usual 'chatty self'. Keisha therefore was mindful of the ramifications of her interactions with her cousins in such a tense atmosphere, and was mindful of the ramifications of her interactions with her cousins in such a tense atmosphere, and she felt uncomfortable talking loudly or displaying any signs of happiness.

Keisha was required to see the doctor to confirm that she was proceeding with the termination and her cousin was not allowed to accompany her. Keisha was told that this was to ensure that the termination was her own decision and that she was not being pressured into it. Following the termination she waited in a recovery room with other patients, and were separated by curtains. Keisha remembers drawing the curtains back and asking the women next to her if she has any food. The women immediately began crying:

I felt terrible. I kind of reminded myself that this is a sad day for some people even though I was never sad.

Quality of clinical care.

Afterwards Keisha experienced some cramping but had no complications and was surprised at how little bleeding there was because she had been unsure what to expect afterwards. ‘Worst case scenarios’ began to occupy her thinking. However, Keisha acknowledged that her experience of the service had been better than she had expected:

I thought like pieces of baby or something would come out but it didn't.

Following the termination Keisha was pleased that a nurse also booked an appointment for Keisha with Family Planning to discuss contraception. Keisha was informed of the risks and signs of post-operative infection such as discharge and fever but was not required to have a post-operation follow-up appointment with her General Practitioner. However, Keisha was advised to reduce the risk of infection by not using tampons and refraining from sex for at least two weeks. She received a medical approach on the day of the procedure, that was mainly concerned with clinical aspects such as discharge, prevention, and symptoms. Keisha was satisfied with this as the termination had not resulted in any distress or conflicting emotions.

Advice to women considering a termination.

Keisha has provided advice to some of her friends/family who have since been in circumstances where they have had to consider termination. One family member had an unplanned pregnancy while she was engaged, had recently moved overseas, and did not have enough money to raise a child. Keisha advised them to not go ahead with the termination:

You have everything else going for you. No one is ever financially ready. There is no perfect time to have a child. You could tell what she wanted – whenever she would talk about it (termination) she would get teary.

Keisha feels that many who either have had or are seeking a termination need reassurance. In this sense, when confiding in people about the decision-making process, Keisha advised being careful about who to confide in. Confiding in someone who has a hidden agenda might be risky:

I think half the time they are just wanting confirmation of their own decision whether that is to terminate or not. Just the same as first time mothers – all they want is reassurance ...It (pregnancy terminations) is a very dangerous topic. Some people could be easily persuaded and it is important to get the right advice from a trusted person.

Overall, for Kesiha the clinical nature of her quality of care was consistent with her expectations. For Keisha, the termination had provided a pivotal moment having come out of an abusive relationship and so she was eager to have her termination, regardless of whether the care was predominately clinical or more interpersonal. The option of being able to return the pregnancy remains to the land helped Keisha to fulfill cultural expectations and obligations, whilst being able to begin a new life.

Case study Three: Arietta

Partner presence at the termination setting.

Arietta had informed Mark of the day of the termination procedure and had initially planned to go with her close friend as she was borrowing her car. The day before the procedure Mark announced that he would like to accompany Arietta as he would find some closure from the process. Arietta initially was hesitant for him to be there as she was uncertain what his mood would be like on the day. In the days leading up to the termination day, Mark was noticeably more irritable and had started to put-down Arietta even more. Reflecting back on why she agreed to Mark accompanying her and her friend to the clinic, Arietta noted:

*I don't know what I was thinking. But in some ways you know like f**k you Mark it takes two to tango you can bloody well see what I have to go through.*

When they arrived at the clinic they got lost and tried to 'google' the location on their phones but no one had mobile data. It was awkward for them as Arietta felt ashamed to ask one of the staff. It was at this stage that Mark suggested he would ask and they were led in the right direction. When they arrived at the clinic there was a security system that required everyone entering to have to state their name and who they were there to see. The waiting room was quiet and was filled with many women, sitting alone or with a support person. This was awkward as the majority of the waiting period was in this crowded room:

*It was awkward everyone was trying to avoid eye contact. There were babies there which was just so f***ed up. My friend was great though, telling me the latest celebrity news and trying her best to keep me distracted instead of being transfixed on that baby.*

Arietta found that the day was made all the more stressful by Mark who continued to question Arietta whilst at the clinic. Mark kept asking her if she was making the right decision and at times would pace up and down the waiting room. Arietta found this very distressing because although her relationship with Mark was not intimate and long-term, she did not want her decision to cause him any pain. She also felt frustrated and confused because she really did not know his views on the termination:

If he didn't want me to have it then he could have just said so. Not stress me out on this day.

Accessibility.

Arietta's sister accompanied her to a different medical centre after she was denied a referral for termination by the last doctor. They both asked if they could speak with a nurse and soon secured a brief consultation. The nurse was helpful and gave Arietta a number of pamphlets, websites, and the names of doctors who she

believed would consent to a referral. The nurse, after asking for Arietta's permission, also telephoned the local hospital to make an appointment for Arietta to see a counsellor. The nurse explained the process to receive a termination and Arietta was quite worried as it seemed lengthy:

You had to do this then that then go to another place and uh. Like I don't have time for this during the weekdays when these places are open. I have a full-time job which isn't easy to get time off for cause my boss was a right pain in the ass. I tried to get it off but he didn't like my excuse cause obviously I had to lie. I ended up calling in sick and argh it sucked. He tried to get me to get a medical certificate so I ended up quitting. We didn't end on good terms but what can ya do?

Arietta was impressed with the doctor she eventually saw. Arietta was also pleased that the doctor was female that she was able to reassure her, and answer any questions Arietta had from her online searches about pregnancy terminations. The doctor explained what the procedure was, what complications might arise, statistical chances of these complications occurring, and where the termination would be held. Arietta was surprised to hear that she would have to travel to Wellington because Palmerston North did not have a termination clinic, only pre-termination counsellors:

I was a bit worried then. I didn't have a car cause you know how small Palmy is right, well yeah so I thought man how am I going to get the money and time off to get to Wellington.

The counsellor gave Arietta petrol vouchers and asked whether she would need anymore financial assistance. Arietta was embarrassed by this and focused on the positives, saying that she was able to borrow her friend's car. Arietta had to borrow money from her sister to pay for one night's accommodation at a hotel that had a private bathroom. As Arietta did not know what to expect, she wanted to feel comfortable after her procedure and have time to rest. In terms of waiting time Arietta was delayed in the initial stages of the termination process owing to difficulties finding a doctor who was willing to refer her for termination. This

delayed the termination process by roughly two weeks. When Arietta had her counselling appointment she had a 15 day wait from the time of that counselling appointment to the termination. Looking back Arietta believes that this might have been due to pressure on available resources:

I vaguely remember the counsellor saying something about how the clinic is only open every Friday or something? So that day was quite busy cause there would be women from all over the lower north island queuing for Wellington.

Interaction with health professionals in the lead up to termination.

For Arietta, her experiences with the healthcare system began once she took a pregnancy test at an after-hours doctor's clinic. The doctor she spoke with was very comforting to Arietta as her initial shock led her to cry. The doctor advised Arietta to think hard about the decision, that a decision did not need to be made immediately but that she should take two weeks to decide. Arietta had many questions that the doctor took time to answer – for example, how far along am I? Who do I go to if I want a midwife? Would a termination effect my future fertility? The doctor said that she was opposed to terminations and that she would be unable to help her if she wanted a referral. The doctor also said that she knew of a young women, much like Arietta, who were unable to have children after their terminations. This was upsetting for Arietta and she left the appointment being certain of the need to whangai:

I thought man there is no way in hell I am going to be infertile from this. How stupid is that. At that stage I really did not feel I had a choice, I always wanted kids. So yeah that was that.

Arietta relayed this information to her partner Mark, who immediately rubbished this claim. Mark explained that his sisters and their friends had terminations and that they had no trouble conceiving. Mark became frustrated by Arietta's reliance on one doctor for information and so they decided together to do some online research. It was here that they found how difficult it was to discern and separate fact from fiction:

You had to be careful what websites you got the link from. If it was something about life dot com or pro family then yeah there were a lot of different 'facts' floating around. Some places saying it is safer than giving birth other websites say terminations will lead to cancer with a 50% chance of infertility I mean yeah... you have to be careful what you read.

During this decision-making time Arietta confided in her friend who also was Māori. Arietta's friend confessed that she had a termination and had not told Arietta because she thought she would have disapproved. Arietta's friend had consulted a local *kaumātua* (Māori elder) about her decision which led to her feeling shame about terminating. However, Arietta's friend noted that some *kaumātua* were more understanding of individual circumstances and could find ways to blend *tikanga* Māori with western ways of knowing and doing. Knowing about *kaumātua* views necessitated a degree of 'insider' knowledge:

Like not being rude but you can tell the kaumātua who are really stuck in traditions. But there are also kaumātua who can blend, without invalidating kaupapa and tikanga. But you kind of really need to know but how do you find these things out and be subtle about it. It isn't a topic that is easy to bring up and you run the risk of being convinced to keep the baby.

After further research and discussion with friends, and a respected Māori *wahine* (woman), Arietta felt a greater sense of peace in her decision to terminate. She approached the same after hours service, roughly ten days after discovering her pregnancy because she and she did not want to go to her regular (male doctor). Arietta felt that it would be embarrassing talking to a male doctor about her situation, especially one who had known her for a number of years. Arietta made an appointment to see a female doctor and when she outlined her situation, this doctor was not particularly helpful:

She pretty much stood up and walked me over to her door and smiled and said goodbye. It was the weirdest thing really. Cause I was standing in the corridor really in shock like okay now what do I do?

Arietta attended one counselling appointment and was told that because she seemed sure of her decision she did not need any more appointments. Arietta did not enjoy the counselling process and felt that it was a 'means to an end'. Arietta was required to be seated on a row of chairs outside of the counsellor's office before her appointment. This was awkward as she made eye contact with the woman who had just finished her appointment, and who she had gone to school with. They both looked at each other and then looked down at the floor. They each felt ashamed to be there:

*It was this awkward kind of oh I know why you are here. Like boom she was out of there and I was the next in line – like...the queue at maccas... next please. Okay not that bad but it felt like it. God I probably saw a thousand people that day (laughs) not a thousand but you get me... it was f***ing annoying. Let's go over my life story for the thousandth time. Like read the notes is it that hard.*

The counsellor introduced herself briefly to Arietta and described her work experience as a counsellor. The counsellor also explained that everything she said was confidential unless it involved the safety of herself or others. Arietta did not feel comfortable producing her mihi and so chose to focus on her family life and plans for her future. During this time Arietta wanted to know more about her counsellor, whether she had been brought up in the same area, what her connections were to New Zealand, but she was too shy and did not want to appear nosey:

I didn't really want to know what her counselling background was, like cool that she was successful and all but I wanted to be able to place her. Suppose it's the Māori way but yeah I found it hard to open up with her after this.

The counsellor got Arietta to explain her decision-making process. She asked Arietta about the father of the child, and whether she was still in her relationship, to which Arietta confirmed. She also explained and asked her about domestic

violence and described the various forms. Arietta got embarrassed at this point, covered her face, and looked to the side:

It was awkward like some of the stuff she was saying he (Mark) probably fits the bill on that. Like he used to twist information and say my memory was bad, these little mind games. I didn't know whether it was abusive though that's a pretty big deal.

Arietta's counsellor continued to enquire and then switched the subject after Arietta mumbled that she was fine. The counsellor then explained the procedure, bringing out a model of the uterus to illustrate the procedure. She informed Arietta what to expect after the procedure, including a period like cramp, and gave her a list of things she would need to take with her to the procedure including pads, water, and something to eat afterwards. The counsellor also explained that Arietta would not be able to have a bath, have sexual intercourse, or use tampons for two weeks following the procedure to reduce the chances of infection. The counsellor also sought to engage with Arietta, calling her by her name, although on many occasions this was mispronounced and Arietta had to correct her. Arietta felt that the counsellor's interactions with her were 'scripted' and that it was not an individualised process that would have made Arietta feel more comfortable:

I just felt like I was on Mars or something. I felt so uncomfortable, like I couldn't say what my thoughts, feelings... and fears were. She was like you're so young and that I hadn't started my career when those reasons weren't the main reasons. I did not want to be tied down to this guy who was horrible to me.

At one stage in the conversation Arietta mentioned that she identifies herself as Māori. The counsellor was surprised to hear this and apologised. The counsellor then proceeded to explain that the remains of the termination could be taken by Arietta for burial and asked Arietta if she wanted to do this. Arietta replied that this was a necessity for her. Arietta theorised that due to a combination of her pale skin and English sounding name, the counsellor may have incorrectly believed that she was Pakeha:

Just pays to ask aye and I guess I was so shy I didn't want to bring it up. I didn't have the confidence to say hey you keep mispronouncing my name and do you mind if I do a karakia. That is just how it goes – the remains go back to the whenua.

At this stage the counsellor then asked Arietta if she had found peace with her decision from a Māori perspective. Arietta confessed that there was a conflict and the counsellor then enquired if Arietta was religious. Arietta expressed being spiritual rather than religious and that she spent a lot of time meditating near the river. The counsellor encouraged her to meditate about it in order to try to find some reconciliation. *Whakatauki* (Māori proverbs) were also encouraged by the counsellor, although she did not have any to discuss with Arietta which might have proved beneficial. The counsellor also was able to provide details of local Māori elders who respected a woman's right to choose. Arietta noted these details down, agreed to meditate on this, and experienced some peace:

I could connect with the river, my ancestors and myself to see that whilst this child was loved, it was not the right time for this child. I later had a dream of my great grandmother rocking this child and covering him with her hands in an affectionate way – like that she will look after him and not to worry.

After this appointment Arietta was required to go to a sonographer to determine the gestation and the most appropriate method. Arietta found this to be an uncomfortable experience because there were many heavily pregnant women, with their partners in the waiting room. This reminded Arietta that she was isolated and the 'odd one out' because she was seeking a termination. During the scan her sonographer was quite clinical in her manner and spoke with an accent which Arietta found difficult to understand:

She looked Indian or something – god knows. But you know the rule of 3 like you can only say pardon three times otherwise it becomes awkward well yeah it was like that. I almost needed a translator. All I heard was pregnancy 12 weeks and that was right at the end of the scan.

Arietta was not concerned that the screen was facing towards her and she was interested in what she was able to see. Arietta expected the scan to be three dimensional so it was a relief to see that the scan consisted mainly of a black and white blob with the sonographer pointing out parts of her uterus including her fallopian tubes and ovaries. At one point, the sonographer mistook her interest in the scan for wanting to hear the heartbeat:

*I understood that part she said you want hear heartbeat in sort of broken English and I was like oh hell no please no no no. She understood but sh*t for a minute there it looked like she was going to.*

The day of the termination.

When Arietta was called in to the clinic she saw a doctor who wanted to double check how sure she was about her decision. He also asked whether she was in a domestic violence- type relationship, whether her partner was here, and whether she felt that he was forcing her into her decision. Arietta felt reassured and safe by this doctor, who also quickly put her mind at ease regarding the consent forms that she would need to sign:

I'm one of those people who reads everything before I sign. Maybe a learnt lesson from my ancestors or something I don't know (laughs). But yeah I had to sign to say I was mental. He (the doctor) explained it as in I would be mentally unwell if I carried the pregnancy. I still didn't like his explanation so he just said it's one of those dumb things women have to do to get a termination legally and that he knows I am mentally sane.

Arietta noted that at times during the conversation with her doctor she was doing her best not to cry. Arietta was aware this doctor had the authority to refuse her termination and so 'putting on the mask' of being relatively unemotional and unfazed was difficult for her. It seems that Arietta was trying to follow the cultural narrative for pre-termination in order to ensure that she would be eligible for a termination:

Like you are allowed to shed one tear but no more otherwise you are just bringing that on yourself. That's what I think and that is actually how I felt that day... yeah...if you shed more than one tear you could be ambivalent or regretful or obviously mentally unstable... So much pressure to perform on a day that was already friggin' stressful.

Quality of clinical care.

After meeting the doctor Arietta was then debriefed by a nurse in a private room. She then was required to walk into theatre unassisted and despite the fact that Mark wanted to come, the nurse firmly stated that partners were not allowed in theatre. This upset Mark as the day was proving to be much more emotional and stressful than both Arietta and Mark had expected. The procedure then began and Arietta was Arietta given gas and other pills to induce cramping. Arietta found the procedure to be surprisngly quick but also more painful than she expected it to be:

Maybe it's cause I don't get period cramps but yeah it was like he was full on tugging at my insides. I was so close to swearing (laughs) must have been the gas cause I was not embarassed then.

When she was left in recovery room, no health professional came to check on her for some time. During this time Mark vented some of his anger toward Arietta and her friend, claiming that he never wanted Arietta to have a termination in the first place. He was pacing the room and shifted between being tearful and using derogatory language. When the nurse came to check on Arietta, the atmosphere was noticeably tense. However, the nurse provided an overview of contraception with her friend and Mark present, gave Arietta some painkillers, and encouraged her to go for a check-up in one month's time. Whilst Arietta felt uncomfortable that Mark was in the room she was pleased to have received more information about contraceptive options:

The nurse didn't stick around for long. I guess the atmosphere was too awkward aye. But yeah I got some info and now I have had the rod in and everything has been going well. I suppose I probably would not have second guessed the contraception until I got those information sheets.

Arietta experienced light and pro-longed bleeding for which she scheduled a follow-up appointment. The doctor tried to ease her mind but sent her for an ultrasound scan which revealed retained products of conception. Arietta was then prescribed a course of antibiotics that stopped the prolonged bleeding. Going back to the same ultrasound provider was quite confronting for Arietta because it brought back memories and heightened her emotions:

It's almost like if you ... I don't know if you say I haven't seen a red car in a long time then all of a sudden that is all the cars you see. Well all I saw for that day and the following day was pregnant women, it is like everyone decided to get pregnant last year (laughs).

Advice for other young women.

Arietta found the process of obtaining a termination stressful as there were many steps and obstacles. Arietta knows that her situation was eased by her friend who was better able to navigate the system, who had confidence to question opinions, and who could stand up, and advocate for Arietta:

She knew what to say, how to stand her ground. If you have a hint of hesitation, shyness or embarrassment you aren't going to get anywhere. You've really got to parade it that you need this termination and that involves facing stigma and disapproval.

Arietta found that having Mark present at the termination clinic was neither helpful for herself nor Mark. She remains adamant that if a woman finds herself in dissatisfying relationships and end up being pregnant then she should break up with the man. Arietta notes that having a support person at the clinic is crucial and she believes that she could not have gone through the termination if she had been there alone. Arietta notes the essential difference between being a 'support person' and an 'additional accompanying person':

Like there is a difference between someone just being there and someone who can put the hard work into making you feel comfortable. Cause I

*knew I needed a termination but Mark's behaviour just confused the sh*t out of me and no women should have to go through that or put up with it.*

Case study Four: Isabelle

Partner presence at the termination setting.

Isabelle had her termination through Tokoroa Hospital and originally wanted to take a friend with her to the hospital. Later on she decided to include her boyfriend in the process, recognizing that he also was involved. He was pleased to be involved, although it was stressful for him as he felt as though he was unable to help Isabelle. This led Isabelle to take her frustrations out on her boyfriend:

I was so hormonal and just so sick that I hated him in a way. Like hated him for doing this to me and it was really hard on him – he was really stressed out. I was always pushing him away because I didn't want to be touched, didn't want to be talked to. I was just in this bubble of making this massive life-altering decision and feeling like ass the whole time.

Isabelle went to see two specialists on the morning of the procedure so they could ensure that others were not coercing her into having a termination. She was informed about the various stages that would be involved for the day. After Isabelle took the termination-inducing medication her boyfriend began to cry. This angered Isabelle as her boyfriend had appeared to agree with her decision to terminate and he was supposed to be there as her support person:

Argh... why... I was like this is not your time. Here I am just focusing on getting through this day and he was crying his eyes out. Then I thought well maybe he can come into the procedure room if it is going to be beneficial for him.

From this moment, Isabelle noticed that the decision was affecting her partner as well and this contributed towards a sense of connection between them. From witnessing her partner's sadness, Isabelle decided that would be best for him to

accompany her to theatre. Unlike other hospitals, the staff at Tokoroa Hospital made it very clear that termination patients were allowed a support person in the room with them. The staff asked Isabelle privately in order to ensure that she was not being pressured by her partner. When Isabelle was first asked she said that she preferred to undergo the procedure alone but closer to the time she changed her mind. The staff were accommodating of this change of plan and began to prepare her for the procedure. Isabelle knew that she had agreed to allow her partner to accompany her more for his sake rather than for her:

I mean it did also later work out for my sake too, having someone there who was there on the day. But at the time it was mainly for him.

When making her decision whether or not to terminate, Isabelle made sure not to rush the process. This was reiterated to her by health professionals and also was an important factor for her when making her decision. Owing to the stress of the situation, and the resultant emotional and physical side effects of pregnancy, Isabelle felt that this delayed her processing of the situation. Isabelle's decision to terminate was identified both as serious and significant and was a transformative moment at a time when she was uncertain as to what direction her life would take:

In fact I probably had too much time. But you know you have to be so sure in your decision and it is better than not having enough time then rushing into it (the termination decision).

Accessibility.

In terms of accessibility, the hospital was reasonably close to where Isabelle's family lived. This required a short drive and therefore minimal cost for fuel for the car that her boyfriend had access to. However, the way that the termination day was structured meant that they were required to be at the hospital all day, and both found that to be tiring:

Granted I know many people who have had a horrendous time – who have had to stay the night there and organise travel costs. But my boyfriend

drove me there it was only about an hour drive. But it was tiring being there the whole day from about 7 till 3 and you are in the waiting room. We were all trying to avoid each other which was kind of a shame because that could be an incredibly supportive environment I guess everyone has come with their own story.

Isabelle felt lucky that there were no protestors outside the hospital because she had heard of instances where pro-life protestors were present. She remembers feeling very vulnerable at the time and is convinced that she would have been extremely upset if she had to walk through a group of protestors:

I think it is so unfair to women. Like this is the most vulnerable group. It's mean, it's nasty, it isn't getting your point across. Like they've made their decision they have come there for a medical procedure in New Zealand which is semi legal, I wish it was more. Live life to your own moral standards but don't try put them on other people.

Isabelle was pleased that all of the doctor's visits were free and this made the termination procedure more accessible and manageable. This was not something that Isabelle had expected when making her various appointments:

It was cool that New Zealand does this. I guess it is about increasing women's accessibility to health care and even if it is a little secretive.

Interaction with health professionals in the leadup to termination.

Isabelle discovered her pregnancy when she visited the university's student health centre. At the time she was unsure what decision to make. While the doctor offered some advice to Isabelle she was unsure what to make of it, given that this doctor came across as being strongly pro-termination:

She said don't let your religion decide your decision. But then she was kind of like well you have only started university you are a female

educated young woman. I think she was really for getting women through education kind of thing but it was a little too pushy in that way.

However, the second doctor she saw was very sympathetic and was a good listener and her doctor. During the mid-semester break Isabelle went home to stay with her family and saw her local family doctor which was a husband and wife team:

I started off seeing the husband but then when I had made my decision I started to see the wife. I don't know whether it was because he was against it or whether it was because he thought a woman doctor would be better to talk to.

By the time she saw the wife doctor, Isabelle was still undecided as to what decision to make. The doctor suggested that she pray for a decision in order to attempt to reconcile her family religious background with the decision to terminate:

Cause she knew I was baptized catholic and had gone to a catholic school. I was thinking well what good is that going to do. But I know she was just trying to give me ways to work through it. But no I didn't pray on it.

Isabelle had a positive experience with her counsellor before the termination. Her counsellor was able to comfort her and provide advice and preparation post termination. Isabelle was pleased to talk through the issues with a person who was outside of the situation. Situating the termination in a historical context and noting the reality of hindsight notably important coping strategies for Isabelle. The use of anecdotes and positioning of herself in time were helpful strategies:

I think she picked up the way I wanted to go. I guess she was the one that told me you know that whatever you decide, 5 or 10 years down the track you have to remember that you made the right decision for you at the time. She told me about an anecdote about a girl who turned to her mum and was like... I know you and dad weren't ready to have me a couple of years

ago. I don't even know if I believe that story but at the time it was what I wanted to hear.

Isabelle had a follow up appointment with a second counsellor on the day of the scheduled termination. The days leading up to the termination were stressful and emotional as Isabelle kept swinging back and forth in her decision-making process. At one point she was afraid that she would not be able to go ahead with the procedure on the day. The mixture of emotions made it difficult for her to arrive at a about her desires and needs:

At one point I had an argument with my dad. I said to him I'm going to have this baby to be spiteful to you. At that moment I knew I couldn't... imagine if that child had ever heard those words you know that I had a baby out of spite. I think deep down I knew what I wanted to do but I got caught up in the emotions of it.

The day of the termination.

Whilst Isabelle was grateful for being able to receive her termination, she acknowledges the 'loopholes' that currently exist. Like others seeking termination she knew that by speaking out this may retrain the legislation. As the law stands currently, pregnancy terminations on social grounds are not accepted as a valid legal justification. Isabelle therefore was required to sign a document to say that her termination was being undertaken for mental health reasons. This was frustrating for Isabelle who views social reasons as implying a sense of blame or lifestyle choice, when such factors can be constraining and powerful:

Like some young woman could not provide their potential child with a quality of life.... We are so conditioned to be mothers above all else. What is the shame in saying it is for social reasons. Who am I to bring up a baby when I might mess them up by not being ready for whatever reason.

The leadup to the termination, whilst at the clinic was a stressful time for Isabelle. As doctors have the final say as to whether a patient is approved to have a

termination, Isabelle was required to put on a mask to cover any contradictory emotions that might surface. Isabelle therefore was well aware of the correct 'social script' for pregnancy terminations:

It was something I wanted and needed (termination). So if you show any kind of emotion they can say no. I mean even the counselors they can say no to it so I wonder what they are looking for. In the waiting room it was a very individual experience and there was no eye contact or talking. It was almost like you felt ashamed if you made eye contact – you kind of feel like you are invading their privacy. I don't know how they could make it more supportive but it does have potential.

When staff asked whether she would like to take the pregnancy remains home, Isabelle decided against it. Reflecting back on this decision she somewhat regretted not taking the remains because she would have had a special place where she could go to visit, something that she finds particularly helpful in healing and connecting with her mother. Planting a commemorative tree was another idea that Isabelle wished she had done, as one way of acknowledging the experience and having something tangible from this experience.

Isabelle's positive interaction with the nursing hospital staff later inspired her to pursue a nursing career. The nurses were talking to Isabelle about the latest in current affairs and other topical stories that were occurring in New Zealand. They provided an individualised approach that focused on establishing rapport and easing patient anxiety:

To me it was really patient-centered care. They were all so lovely. Talking about the Scott Watson thing and just took my mind off things.

Looking back Isabelle realises that the care and support that she received from the nurses when she received her termination was what prompted her to consider a career in nursing:

I saw how amazing those nurses were and how they eased my mind at that time. It really made me want to be the one to crack a few jokes, hold patient's hands, you know like help others like they helped me.

Isabelle felt comfortable in her interactions with health professionals and they interacted with her in a manner that was consistent, and respectful of, her culture. Having rapport and a sense of personal warmth and connection was very important for Isabelle when she went for a termination. She was very impressed with the quality of care that she received from the nurses. After the procedure Isabelle enjoyed some chocolate and felt relief as her nausea immediately disappeared. She was briefed about what to expect regarding bleeding and the signs of infection, and informed about any restrictions on activities over the weeks that followed.

Quality of clinical care.

In terms of the procedure itself, Isabelle was calm going into this and felt prepared. She was given an outline of what the dilation and curettage (D & C) involved and had any questions answered. On the day of the procedure, she was given gas to ease her anxiety and this allowed her to clarify her thoughts and to be completely comfortable with her decision.

After her termination, whilst at the hospital, Isabelle was provided with advice about contraception. This was viewed in a positive light and seen as an opportunity to talk about contraceptive options and how to prevent future unwanted pregnancies from happening. Isabelle had lost all confidence in the mini-pill and this opportunity provided her with an avenue to learn more about the variety of contraceptives available that could alleviate her heavy periods:

I think it was so important that the nurses did that (discussed contraception). It is important to talk about how to prevent this from happening again. So for me, I was able to get free Mirena. The funding cycles always seem to change and so this was a good option for me and it

was something affordable... I do shift work and for me, the pill really wasn't a good option to have to take it at the same time every day.

In the nights following the termination, Isabelle had difficulty sleeping so she visited her doctor and was prescribed anti-anxiety medication. However, in the case of her studying psychology papers, one of her lecturers presented a seminar on anti-anxiety medication and outlined their addictive properties. This combined with the effect they had on Isabelle led to her flush the medication down the toilet.

Whilst reassured by the decision to terminate, Isabelle was totally unprepared for the sense of emptiness following the pregnancy termination because, for Isabelle, the pregnancy termination had reactivated her sense of freedom. Amid the chaos of time-pressured decision-making and the reality of not knowing what to expect having never experienced this before, Isabelle was surprised at the feeling of emptiness she experienced. Given that the experience is so personal and rarely discussed due to fear of stigma, she expected that her experiences would have resulted in tangible 'gains' rather than 'freedom from':

I feel like with termination you have nothing from it. If you have a baby or you choose to adopt it you have something tangible there as in you have made someone else happy. But then you come to the abortion and it's like what is my tangible thing? That I can continue living life? I feel that it is an empty process almost like you come back from it empty.

In an attempt to resolve this sense of emptiness, Isabelle opted to get a tattoo. Her tattoo was a tangible way of giving her experience validity, acknowledging actually that it did occur, and that she had learned that she is more resilient than she previously thought. Her tattoo accompanies one that she received in memory of her mother. Although laughing at the artistry of the tattoo, she feels that it gave her a sense of closure for her pregnancy termination. Feelings of social stigma and censoring who she confided in also meant that the experience seemed surreal and almost nullified. By getting a tattoo, this experience was validated:

I remember reading something where it said you know, you are allowed to grieve. Just because you made that decision, you are still entitled to the grieving process.

Advice for women considering a termination.

It is important for women to be sure of their decision to terminate before confiding in others. Sometimes, when confiding in others too soon, this can lead to greater confusion and make it very difficult to segregate and 'filter' the opinions of others:

That is something I wish I did you know. Like made sure of my decision before talking to others, especially my father. No matter how I look at it maybe he did influence my decision. I wish it had been more my decision. Cause I don't know how much of it was my own. I still probably would have terminated but there is sometimes that niggling doubt.

In this situation, Isabelle perceives herself as being a listener for a friend. She would attempt to rectify any misconceptions and offer unconditional support. The importance of arriving at a decision that is right for the woman involved is something that Isabelle would reiterate. In the aftermath of a termination, she would advise young women always to remember that the decision (to terminate) was the right one at that time and that reflecting back on the decision at some later date is futile. Isabelle also believed it is important to take time out for oneself and to explore one's own emotions so as to avoid confusion when confiding in others. Isabelle concludes, the experience of a termination is also highly individualistic:

Everyone's experience is different. Even if I told them my experience, like that isn't necessarily going to be the best action for them.

Having a support person to accompany a young woman for the procedure is also vitally important. In this instance, a supportive person is someone who would support the woman, even if she changed her mind regarding the termination. Sharing this experience with another person can be helpful especially if emotions

are intense in the months that follow the termination. This sense of connection and the ability to communicate one's emotions was a turning point for Isabelle:

I think it is really important (to have someone there). It would be so hard to do it alone I mean people do but... full credit to them. To have someone there is good for if months later you are really struggling, someone has seen you on the day and saw everything you know.

Case study Five: Rachel

Accessibility.

In the leadup to the termination, Rachel did not have any transport and had a young son at home. Her doctor subsequently arranged for the social worker to visit her at home. As Rachel had not told her parents about the pregnancy, as she was not sure that they would support her decision to terminate, she convinced them that the social worker was a community mental health social worker. Rachel did this because she was aware of her parents' strong opinions regarding having a child out of wedlock:

I kind of had the sense already that I had stuffed up because I had already had a child. In my family it is not how you are meant to do things. I had a child, I did not have a partner and I did not know what I was doing with my life – they would have been like oh my god you stuffed up again!?”. It was easier not to deal with their reactions or emotions. Even now I will pick who I tell very much so. I would tell people if it was for a reason. I don't tell people you know – just because (regarding termination).

Whilst Rachel was grateful that she did not have to organise transport and childcare, she felt a little bit uncomfortable because her son was present at the time and she had not been able to organise childcare. At one point, during conversation with the social worker, Rachel felt particularly uncomfortable:

She basically said to me well you've got a child, why would you choose to have that one and get rid of this one?. I firmly said that I did not want another child and so the social worker signed the paperwork in the end.

At this stage she was living with her parents in Rotorua and therefore had to travel to Auckland to receive the procedure. Rachel told her sister about the pregnancy, then they told their parents that they were going to Tauranga to visit one of her sister's friends. They used her sister's car and took a porta-cot for her son to sleep in. Rachel went to the termination clinic alone while her sister kept her son entertained in Auckland:

My sister hadn't spent that much time with my son at all. We just didn't know what else to do.

At the time of her termination, Rachel did not receive financial support in terms of any petrol or accommodation reimbursement or subsidies. She and her sister had hired a cabin in a motorcamp to stay the night and then returned home the next day. Whilst this was not a significant barrier, the geographical distance to the hospital meant that access to a vehicle was necessary. For Rachel, this meant co-ordinating a time with her sister so that she could be taken to Middlemore Hospital. Despite the travelling time of close to three hours, Rachel did not experience any significant waiting delays in the availability of termination procedure appointments. The appointment was organised within two weeks and arranged to fit with Rachel's sister's schedules.

First encounter with terminations.

Rachel announced her decision to her doctor concerning the pregnancy. The doctor tactfully and respectfully, said that termination was against her beliefs but that she would find a doctor that would be able to help her:

She made me feel like there was nothing wrong with me but that it was just about having a different point of view.

Rachel then went through the various procedures to get a termination, which included having scans and swabs taken. However, during these stages she became unwell mentally and telephoned the crisis hotline. The crisis team member, who she had met before, worked very hard to get Rachel into a service that had better conditions than other psychiatric hospitals. Because Rachel was pregnant she was admitted into a service called 'Mothers and babies' for mothers who had post-natal depression. The overall aim of the service was to ensure that the baby would be cared for and that an emotional attachment would be formed between mother and baby. This 'Mothers and babies' service was combined with the Eating Disorder Unit – most patients had anorexia and/or suicidal ideation. Rachel thought this was quite bizarre because the two groups had so little in common.

Rachel was at Princess Margaret Hospital when she had her scans and swabs taken as part of prenatal assessment. Owing to her trauma history, Rachel was upset to learn that she was carrying a boy and that no one referred her to a psychologist or counsellor, despite her having informed every health professional that she wanted a termination:

So I kind of ended up having a baby by default because nobody talked to me or organised anything. All that happened was basically I was fed and made sure that I was not killing myself.

This was an extremely difficult time for Rachel as she was in a very depressed state and felt unable to function as a human being. While she was living in Christchurch she got back with an ex-boyfriend (not the father of her child). He supported her when she was admitted to hospital. By the time that Rachel was out of the hospital it was too late to terminate legally and so she confided in her parents. She moved back home with her parents and gave birth to her son.

Prior to the development of this relationship, Rachel had visited her doctor to request contraception. The doctor suggested the contraceptive pill which she refused because the hormones contained in it made her unwell. An Intra Uterine Device (IUD) was then suggested but initially she was resistant to this having previously fallen pregnant with an IUD. However, her doctor reassured Rachel

that statistically there was very little likelihood of her becoming pregnant and so she agreed to have the IUD.

Rachel's partner had visited her briefly in the North Island and it was during that time that she felt as though she had fallen pregnant. This was one year after she had her first child. Rachel's partner approved of her having the termination because he was not ready to have a child and was still studying at university. Rachel returned to the same doctor and told her that she felt pregnant. Initially, her doctor tried to assure her that she was not pregnant but a pregnancy test confirmed her suspicions. Rachel sensed that her doctor was very embarrassed by this revelation, as this pregnancy had happened within one month of IUD insertion. She told her doctor that she definitely did not want another child as she already had a child. Rachel was relieved when her doctor gave her a referral and said that she could understand her circumstances.

Interaction with health professionals in the leadup to termination.

Rachel's progression through the various channels to get a termination was relatively straight forward. Both the interactions with the sonographer and doctor at the hospital were positive, with the ultrasound likened to a pelvic scan. The doctor also provided detailed information about informed consent, what the procedure entailed, and reminded Rachel that she could change her mind at any time. Rachel did not see any health professionals after the termination and did not experience any complications Rachel had no experience of any stigma through these two processes:

They did really put a lot of emphasis on you can change your mind at any time. That was right up until we give you... the pre meds to loosen up your cervix and once we give you those it's your deadline. They did really emphasis that there is no judgement. As in no one will be pissed off with you for wasting time or anything like that. We just want you to make the right decision.

Having experienced the termination system to varying degrees on two occasions, this gave Rachel more confidence to articulate and assert her desires. The environment, on the second occasion she had entered the termination system, was more logically organised and in a sense, relatively straight-forward. As her mental health had improved greatly, Rachel was able to ‘work’ the termination system in a way that ensured a referral and a successful outcome for her:

I think from having my son, you know being a single parent then finding out that he had developmental issues and those sorts of things. I think that made me a lot more clear and a lot more assertive in myself. I wasn't in the middle of this huge depressive patch that I had been in. The first time I was in a really weird environment. In that environment it was hard to identify who to talk to and what the process was and very isolating.

The day of the termination.

When Rachel arrived for her procedure in Auckland, she found the staff to be quite ‘matter of fact’. Rachel was asked very few questions at the clinic and noticed that most people in the waiting room were alone. The waiting room was sterile and the atmosphere tense, with everyone attempting to avoid any eye contact. Because Rachel was not sedated in theatre she vividly remembered the procedure. However, she did not mind being awake as this gave her a sense of control and an awareness of her surroundings. Feeling in control was particularly important for Rachel because of her history of trauma:

I'm one of those people where if you let me do it myself I will do it myself. If I had been allowed to have done the termination myself I would have liked to because I like to know what is happening to me all the time.

The waiting room atmosphere was well-suited for the expectations and preferences that Rachel sought from the termination service. As the termination was seen in medical terms by the hospital and Rachel herself, this was a perfect fit in terms of patient-centered care:

I don't think that it particularly worried me... I mean it was quite impersonal and I didn't have a problem with that.

Quality of clinical care.

Rachel found the procedure to be very quick and she was surprised how painless it was in comparison to a smear test. She then was required to wait in a recovery room where everyone was separated by a curtain. Rachel was surprised to see her sister enter the recovery room with Rachel's son. Having her son in that environment was a strange feeling for Rachel, as she was mindful about others in the waiting room:

Weirdly they let her come in with the baby and I'm like this is kind of weird... I wasn't worried but I was sitting there going what it's like for all the other women post-termination and their families to have this baby arrive. It just seemed very odd that they let that happen because it would not have been very respectful for other people.

Because she had not been sedated, Rachel was discharged quickly. She left with minimal pain relief, having only been given Panadol. Rachel experienced some quite cramping following the termination but did not have any other side effects.

Rachel felt prepared both for the procedure itself and throughout the different stages of the termination. She was prepared in terms of her knowledge about medical aspects and pain levels, having known in detail what instruments and medications would be used and taken respectively. Despite not having a needle phobia, and having previous experience with needles, Rachel was nervous about the injections and how painful this would be:

I was nervous about the injections in the uterus. That was the bit that scared me because I thought it might be horrendously painful. I was really nervous that I would be able to see a needle or something. I'm not needle phobic but the thought of having someone stick a needle there.

Fortunately, Rachel experienced only a very low level of pain from the procedure. Although not a source of great distress, Rachel nevertheless was surprised that, following the procedure, she was led into a room that had other women who also had a termination.

I think the one thing I didn't {expect} is that after the procedure you are in a room with a whole group of people basically. There was just curtain dividers into the areas. You could hear everything that was coming and going. There was no privacy at all.

Advice for women considering a termination.

In terms of advice, Rachel advises young women to consider their rationale and to reflect critically on the reasons why they are choosing a termination. Taking time to make this decision yourself, rather than pleasing others, is seen to be an important way of seeking closure with this decision:

Both if you are keeping the child and if you aren't (consider why). Being mindful in trying to understand what the pros and cons of what you are deciding. You know like pay some thought. I think maybe just really think about it then you might be more comfortable about it later I don't know. I've noticed that those who have been pushed through with terminating, if you are being heavily influenced by a number of people I think it is very easy to just go along with it.

Although Rachel is aware of varying experiences with terminations, she views her termination as being a benign event that occurred in her past. The termination is firmly grounded in time, and is reflected upon only when Rachel thinks about falling pregnant again:

The termination was a very very small little piece {in my life}, it was something that happened. But it was not a huge milestone, dip or anything. It's a small sequence of events. I know people might have recriminations or regrets or what ifs but I never had any of that. It doesn't haunt me.

Rachel had a positive experience of her termination and it appears that the main variables driving this are her determination not to have any more children and the association between desired and actual quality of care outcomes. The certainty of not wanting children enabled Rachel to disconnect from the pregnancy and termination experience. Having attempted to navigate the termination system on two occasions gave Rachel knowledge about how to 'work the system'.

Case study Six: Megan

Partner presence on the day of the termination.

Oliver felt that if he could hold Megan's hand during the procedure that would be his farewell and allow him a sense of closure. Megan approved of the idea and they would both be able to support each other at that moment. They had discussed this with the Waikato hospital staff when they arrived and staff said they would write this on their file to remind all other staff. This reassured Megan and Oliver, in particular, who was striving for closure.

However, in the operating theatre when Megan asked where her partner was, staff told her that they were happy for him to be there with her. She was then reassured by the surgeon, who tried to put her mind at ease, and explained that Oliver would arrive soon. When Megan was led to the recovery room she discovered that Oliver was not there and that the nurses had distracted him during the procedure. Megan was struggling to process the decision that she made and this was compounded by Oliver's obvious anger at having been led to believe that he would be able to be present with Megan in theatre:

He was meant to be supporting me but I had to support him. That was really awful and I had just made this life-changing decision. It would have been to have gotten a hug and be told that I'm going to be okay. It was horrendous – I was trying to process what had happened and provide emotional support for him because he was losing the plot.

Megan remembers spending much of her time in the recovery room worrying and problem-solving with Oliver so that he would not punch a staff member. Megan realized something was seriously wrong, as he normally was not an aggressive person. Owing to the combination of drugs and the rapidness of the procedure, Megan was struggling to understand what had happened and why her boyfriend was so angry:

I don't know what they had given me but I was so confused and couldn't work out why my boyfriend wasn't with me. Here's me thinking he was coming with me. They pretty much split us up.

However, when the nurse did a routine check-up on Megan, Megan asked for an explanation why Oliver had not been allowed in theatre. The nurse explained that what Megan and Oliver had been told was incorrect:

She said that I don't know why you were told this because it isn't our policy. Our policy is we don't let partners in with women because they can quite often upset the patient more.

This was a stressful experience for both Megan and Oliver and only added to the negative experience of quality of care. It also reinforced the medicalised nature of the termination where rules and policies were rigid and patients not treated as individuals. Megan acknowledges that if they had been informed prior to the day of the procedure then their experience would have been less negative:

I had kind of come to terms with my decision. I had the reasons why I shouldn't have this child and I could rationalize it. But for my partner – he was livid at the system. I just wish they had said at the start that he wasn't allowed in there then he could have spent his day getting his head around the fact that no he was not going to be allowed in the operating room. You know... he could have sat on a chair outside the theatre. There are ways around doing things rather than a blanket number.

Accessibility.

In terms of accessibility for the termination, Megan had no financial constraints that made achieving a termination difficult. She was not working at the time, was studying by correspondence, and living near to Waikato Public Hospital with transport easily arranged. Megan notes that it was six weeks from the time that she discovered her pregnancy, as confirmed by her doctor, to when she had the termination:

I saw my doctor; she said go away and think about it for a week. So that was a stand-down period that the doctor imposed. Then I came back and said yes I want a termination and she said that was fine. Then that's just when it was booked in. As far as I know that was the next available time. I don't know how often they have the day procedure type thing, like it might only be a few times a month.

The layout at Waikato Public Hospital at the time, the hospital layout determined that the termination unit was very close to the mothers and children unit. Megan expresses uncertainty about whether she could go back there as she had retained some vivid memories of the hospital:

I don't know like in the future when I have children. I don't know if I could go back to that hospital because I definitely think that would bring back some memories and interesting flashbacks. The guy that was doing the procedure was also an obstetrician so that would be really interesting if I was to ever run into him again. A situation like that would get very emotional very quickly. I think some things just etch themselves in your mind no matter how hard you try and forget them.

Although Megan acknowledges that she was briefed about the procedure by her doctor and at the hospital that day, there were events throughout the day that surprised her. The close location of the termination clinic alongside the neo-natal unit troubled Megan, as she was confronted with pregnant women:

It was close to where there were pregnant women around and I thought I don't know how I feel about this.

Interaction with health professionals in the leadup to termination.

Because Megan's doctor had explained the procedure, this reduced Megan's stress about the termination. Her doctor's sympathy and knowledge were calming influences, and Megan saw her doctor more as a relational person than a strict professional. Megan acknowledges feeling very comfortable around this doctor, as she had been her doctor for a number of years:

She is not the type of doctor to write me out a script and show me the door. I know I have dealt with other doctors who are like that – the kind who are like here's your prescription I don't want to see you again. My doctor knows my life story. She is kind of like a mum but with a medical degree and probably a bit more professional. She has got that human touch.

Megan saw a social services professional in the lead up to the termination. She explored Megan's decision-making and the context of the decision including her parents' separation. This professional also recognised and respected Megan's individuality and told her that she may (or may not) want to know certain aspects of the pregnancy:

She kind of asked why I was making the decision to terminate. To me it kind of turned into a conversation about my parent's separation. I hadn't really talked about it with anyone really at the time either. It was a good opportunity to talk to a professional... I do remember being asked if I wanted to see photos of how old...like the size of the fetus or whatever would have been at the time. I remember thinking no.

This social service professional also explored Megan's relationship with her partner, Oliver, and asked on a number of occasions whether she was in a domestic violence relationship. Megan felt comfortable discussing her situation with Oliver, his jealousy, and her parents' emotionally abusive relationship:

Domestic violence is very layered. But people sometimes forget about the emotional and mental abuse, which is certainly what he put me through (Oliver). I also had my parent's relationship that was emotionally abusive and it was quite toxic to live in.

Megan was required to obtain an ultrasound to determine the gestation and to decide what procedure would be used for the termination. However, as they could not detect the heartbeat she was required to go back for a second ultrasound. Megan still was anxious as to whether she would be able to have a termination, as she has been advised it was strongly advised that earlier terminations are safer and legally easier to obtain:

By the time I had the second scan done I think I was about 12 weeks so I was kind of borderline as to whether I could go through with it. They didn't seem to have any problems with it. Before I went in for the termination I was seated next to someone who was 14 weeks and I went before her – when I was told beforehand that those who are further along go first. That was interesting too because I thought if you were 14 weeks you had to go for a second trimester termination – that line of what procedure to have when isn't so defined.

Oliver was not able to be there for the scan as he was studying in another town and could not get time off. The sonographer asked Megan whether she wanted to see the ultrasound screen and she agreed. When reflecting on the sonographer's interactions with her, Megan noted that she while she was a bit 'clinical', she was but was non-judgmental and that was more important for her:

She was nice enough, business like, and diplomatic. I didn't feel like she was judgmental so that was nice. I felt like it was quite intrusive though – I also had to do one of the probe things (where it went inside). She told me about all the things that she could see on the screen and to me that was fascinating.

When Megan saw the ultrasound picture, she was not negatively affected by it. She found it interesting to be able to see it and was glad that she had decided to be shown the screen as she felt that this confirmed the process and experience as being ‘real’:

I'll never forget seeing that little blob on the screen. It is pretty marked in my mind. One thing I kicked myself for not doing is getting photos of the scans but I'm sure there is something on the doctor files. Being able to say that it was a physical thing and it did happen is something altogether.

The day of the termination.

When they arrived at the clinic, Oliver and Megan were seated in the waiting room and felt quite awkward that others were in the room: “everyone knew why everyone was there”. Megan watched the surgeon shake people’s hands and noticed how he led them into his room in a way in which she felt uncomfortable:

He shook their hand outside of his office and then dragged them into his room. He felt oily... I am definitely a personal space person.

When Megan was in this surgeon’s room she felt rushed and reasoned that this could partially be due to his desensitisation to the process. The surgeon appeared to give off a strong vibe of “*I know why you are here*”. Megan was then required to have the medication in the room.

Megan also had to walk into the surgical theatre with no nurse to accompany her. Later, when she was in the post-op room, no nurse came to check up on her until some time after the procedure. Due to the medication she had taken, Megan felt ‘spaced out’ and initially was quite hesitant to take them, as she did not understand what was in them and what side effects there might have. These questions were answered later following the termination, when she still felt quite ill and ‘dopey’.

Quality of clinical care.

When reflecting on her experiences of termination process Megan notes that it was very rushed and that felt more medical than holistic and relational. This did not align with her expectations and preferences surrounding quality of care, and contributed to a sub-optimal experience of a pregnancy termination. Long waiting room times, combined with being rushed whilst in the queue led towards feelings of being a ‘number’ than a unique individual:

In terms of support of the hospital staff I was thoroughly ticked off about that. Also I guess I felt like I was just brought in and rushed into surgery and there wasn't kind of a chance... we were left out in that waiting room for ages. Like we were the last group to go in then it was kind of like put your stuff there, take this pill then go in there. It would've been nice to have been brought in even half an hour earlier and I guess a little more hand-held through that experience. I guess you know being the end of the day they would've been like oh look here's another one you know. In and out kind of thing. It would have been nice to not be another patient put through the revolving door. It could've been a lot more humanized.

When Megan was about to be discharged she was given information about what to do thereafter. The signs of infection were explained carefully, what she should expect for the next two weeks, and what activities to avoid. The nursing staff gave Megan some paracetamol to relieve any post-operation cramping:

They gave me a pamphlet about making a follow-up appointment with my GP. It is in my box – I have a box with all that stuff in it. You know like the hospital bracelet and original pregnancy test. I guess for me that was a way of acknowledging that that actually happened.

Megan also was disappointed that the nurses did not do more for them. Megan theorised that because the atmosphere in their room would have been strained and awkward, health professionals would have regarded it as a private matter, something for them to manage together and alone, without further involvement

from hospital staff. Having a more individualised care approach might have reduced any anxieties and emotions resulting from any change in expectations and agreed plans:

I mean surely the nurse recognised that my partner was having issues. It was kind of like oh no you guys are all right you know? It kind of felt like quite dismissive – lets get you out of the door as fast as we can. Like I would've really appreciated to have been left alone away from him. If they identified there was an issue they could have let him talk to someone – a doctor or whoever and received some sort of apology then he would have been in a better place and more supportive for me. I also needed someone just anyone to say to me look you're going to be okay, just that reassurance.

Post-termination counselling.

After the termination Megan was offered post-termination counselling. Because of her circumstances and her being needed by other people in her life, including her mother, and her boyfriend, Megan postponed counselling. Working through the termination at a later and more suitable stage in her life was beneficial for Megan:

For me everything kind of came to a head when I split up (with Oliver) and the suicide type crap. That kind of compounded like with going through the termination I kind of realized that there were issues that weren't resolved. My parents had also furthered the process of separating and so with all that going on... I kind of reached a brick wall. At that stage it was good to dig it all out and talk about it and work through all the issues. It definitely helped – tissues came out.

Megan describes herself as not being a talkative type, preferring to put things in a box and trying to forget about them. However, upon realizing this strategy was not working she took steps confronting her situation. The social services professional that Megan saw helped her to look deeply into issues that occurred

around the time of the termination and gave her strategies to cope with managing her mother, learning to say no to people, and having an adult relationship:

I guess for me I'm a person who externally rationalises. Things can just go round and round in my head and I'm thinking oh god how god I don't know how I'm going to cope with this and just trying to forget about it. That obviously wasn't working and so I had this opportunity to talk it through.... He helped me.

Advice following a termination.

Upon reflection on the advice that Megan would offer any young women who were considering a termination, factors such as family support and seeking counselling immediately came to mind:

I wish my mum was prepared to open up and talk about it. I think as well even if you don't want counseling at the time I think it is probably even a good idea even to just turn up and go through the exercise of doing it. Just to exercise those demons and nothing else. I kind of kicked myself that I didn't take it up at the time – that is hindsight for you.

Looking back on how best to navigate the termination process, Megan learnt through her own experience that promises can be broken. Specifically, she would like to advise young women that partners are almost never allowed in to the operating theatre room. Megan also invites young women to think of ways in which their partner can gain a sense of closure in order to ease subsequent post-termination relationship transformations and difficulties:

It doesn't matter what they say to you there is no way they are going to let your partner in there so don't even get your hopes up... But I think there is a certain way of allowing him a sense of closure too. Men want to fix things and be there for you naturally. I think you know it took both of us to get into that situation so both of us should be getting out of that situation. I think that is quite important.

Megan notes that having the support of her boyfriend not only affected the overall outcome but also it had a significant impact on coping afterwards. Megan encourages other women in this situation to seek support from their partners if possible, acknowledging that in her case having partner support would have helped her to cope better:

I am surprisingly still quite ticked off about that (her boyfriend not being allowed in the operating room). Interesting given that enough time has passed for me to get over it. But I definitely think that if he had been supportive it would have almost have been a non-event – life would've probably just have gone on.

Megan had a negative experience of a pregnancy termination owing to the combination of her partner's emotions and ability to cope post-termination, as well as unexpected realities on the day of the termination. Having planned for her boyfriend to accompany her to theatre, Megan and Oliver subsequently felt betrayed because they had lost the opportunity for 'closure'.

Chapter summary

This chapter has explored the components of quality of care that contributed towards young women's overall experiences of a termination. This chapter has documented these experiences that followed from the participant's earlier narratives concerning intimate and future relationships as discussed in Chapters Four. The following chapter, Chapter Six, will analyse these participant narratives in light of the existing academic literature.

Chapter Six: Discussion of results

This following chapter further examines the findings from the six participant case studies. A comparative analysis is undertaken using a thematic approach whereby themes emerging from individual narratives are discussed in the context of the existing literature. Whilst the previous chapter (Chapter Five) has described and interpreted the results, this chapter will discuss these results in light of ten themes that have emerged from the majority of the narratives. These themes provide both a broad and an in-depth analysis of the experiences of young women who have had a termination in a New Zealand based setting.

A series of tables will be presented for each theme. Where there is a '✓' symbol under a column then the participant experienced this phenomenon. When there is a space alongside a participant's name, this means that this participant did not experience this phenomenon. The designation 'N/A' (not applicable) was used in those instances where participants ceased their relationship prior to termination, or when a participant did not have children when asked a question concerning childcare arrangements.

Part I: Intimate relationships: current and future

This section outlines themes concerning the bidirectional relationship between pregnancy terminations and intimate relationships (both current and future). As will be revealed, pregnancy terminations tended to occur in novel and intimate relationships, adding stress and conflict in some cases. Pregnancy terminations can have the *potential* to disrupt intimate relationships, and often these provide a pivotal moment or further confirmation to conclude the intimate relationship. Unfortunately, as Coleman, Rue, and Spence (2006) noted, there is a considerable absence of literature in this area: "Surprisingly, little focused scholarly attention has addressed how abortion is likely to impact relationships" (p.11).

Goodbye honeymoon phase: “I feel robbed of that time”.

For many participants, their relationship with their partner with whom they fell pregnant was a fairly new relationship. This meant that young women had expected to experience the ‘honeymoon phase’ in their relationship characterised by euphoria, idolisation and focus on pleasing their partner, celebrations and gift-giving, and having relatively few arguments. This phase usually lasts up to 24 months and also involves fun, adventure, light-heartedness, and a series of steps that involves gradually getting to know one another (Lorber, Erlanger, Heyman & O’Leary, 2015; Spencer, 2015). Furthermore, the ‘honeymoon’ phase commonly includes partners engaging in ‘idealisation’ where individuals project their ideal characteristics onto their partner and genuinely believe that their partner naturally possesses these (Lovendale & Duffell, 2002; Spencer, 2015). The ‘honeymoon phase’ might also be characterised by a sense of mysteriousness in partners liking to control how and when they reveal characteristics and traits about themselves (Lovendale & Duffell, 2002; Spencer, 2015).

As seen in Table 3, most participants fell pregnant in a relationship that was up to six months in duration. One participant (Megan) was in a relationship for approximately 12 months. No participants experienced relationship longevity of more than 12 months, in the lead up to termination.

Table 3: Length of relationship at the time of pregnancy

Participant	< 3 months	3 – 6 months	6 – 9 months	9 – 12 months	Sense of loss over ‘honeymoon’ period
Jenny	✓				✓
Megan				✓	✓
Isabelle		✓			✓
Arietta	✓				✓
Keisha			✓		N/A
Rachel	✓				N/A

Following a termination, those partners who were in new relationships (and in a relationship at the time of termination) felt some sense of loss regarding the 'honeymoon' period. In this sense, relationships progressed to a more serious and deeper level of connection, having by passed the 'fun' stage with minimal arguments (Spencer, 2015). Whilst by passing this 'honeymoon stage' has the potential for enhanced intimacy, most participants had felt 'robbed' of the initial stages of their intimate relationship. A termination therefore has the potential to propel intimate relationships into a deeper sense of commitment and intimacy; however, partners need to be effective communicators and be respectful of one another. The novelty of this relationship therefore can create tension as a relationship progresses to a stage prematurely, without adequate emotional and relational resources (Coleman, 2007).

A loss of the honeymoon phase, however, did not translate to an increase in conflict within the intimate relationship. Typically the advancement of a relationship leads to a greater sense of comfort in the relationship and the likelihood that arguments would increase (Spencer, 2015). Participant narratives in this thesis provide a contrast with prevailing literature that documents an increase in conflict following termination (Coleman, Coyle, Shuping, & Rue, 2011). With a termination in a current relationship, research has discovered that conflicts over finances increased by 75 per cent while conflicts concerning either partner's relatives increased by 80 per (Coleman, Coyle, Shuping & Rue, 2011). Further research is needed to determine whether variables such as participants not living in a de facto relationship and not knowing family members intimately are influential and significant.

Exacerbating and hastening intimate relationship issues: "it made our relationship spiral out of control".

Pregnancy terminations have long been cited as impacting on intimate relationships in various ways (Coleman, 2007). Whilst there is limited research that suggests specific ways in which a termination affects an intimate relationship, relationship duration, trust, and commitment have been identified as important contributors (Coleman, Rue, & Spence, 2006). The quality of the relationship is

an often-neglected component when examining this correlation, and this has been addressed through this thesis.

The following table, Table 4, identifies the participants who were in novel or unappealing relationships and for whom the relationship ceased directly due to the termination experience. The 'N/A' stands for Not Applicable and applies to Keisha and Rachel because they already had broken up with their intimate partner before termination.

Table 4: Participants whose relationship was prolonged or dissolved due to termination, and who were in an unappealing relationship

	Termination as prolonging the intimate relationship	Unappealing intimate relationship	Relationship dissolution post-termination primarily due to termination experience
Arietta	✓	✓	
Megan			✓
Keisha		✓	N/A
Rachel		✓	N/A
Isabelle	✓		
Jenny	✓	✓	

Table 4 shows whilst four participants were in novel or unappealing intimate relationships, and this was a contributor towards the decision to terminate. Only one participant experienced a relationship break-up predominately as a result of the termination experience. For other participants in unappealing relationships, the termination prolonged the relationship if the intimate partners were supportive, leading some participants to temporarily be confused about their feelings for their partner. For Isabelle, the termination provided a pivotal moment in her relationship, and in fact prolonged the relationship.

Consistent with international research, participants in this study tended to be in a novel or dissatisfying intimate relationship serving as a prompt to termination (Ring-Cassidy, & Gentles, 2003). The fate of their relationships generally followed similar patterns as found in contemporary research where approximately 40 to 50 per cent of relationships dissolve, or are significantly altered, following a termination (Ring-Cassidy, and Gentles, 2003; Rue, Coleman, Rue & Reardon, 2004). Barnett, Freudenberg, and Wille (1992) found that ending a relationship was initiated by 80 per cent of the women in the sample, with 60 per cent specifically attributing this to the termination itself. Research by Sherman Mandelman, Kerenyi, and Scher (1985) provides alarming rates of relationship dissolution as high as 75 per cent. However, more recent research by Lauzon, Roger-Achim, Achim and Boyer (2000), have noted that 12 per cent of women believed their termination was a central reason for the dissolution of their relationship. It is significant to note that these studies alone do not provide sufficient detail concerning the *characteristics* of the relationship preceding termination. It therefore is important to consider particular *contextual factors* rather than a sole focus on the dissolution of a relationship because for many young women relationships frequently dissolve and this often has no bearing on the termination itself (Chibber et al., 2013; Mauldon, Greene, Foster, & Roberts, 2015).

What appears clearer for the prognosis of relationship difficulties is the view of the termination as taking away a life, a preference for avoiding a termination, an emotional connection with the pregnancy, and experiences of grief or guilt following the termination (Coleman, 2007). Specific hypothesised relationship factors that might help to buffer relationship dissolution include the length of a relationship, commitment, trust, and the extent to which there is open and frank communication (Coleman, 2007). Intimate relationships are generally no more likely to cease post-termination than relationships where those involved do not have to confront this decision and experience (Robbins, 1984). This occurs despite prevailing societal myths that terminations invariably result in relationship dissolution due to the associated emotions and stressors involved (Mauldon, Greene, Foster, & Roberts, 2015).

This thesis supports earlier research (Robbins, 1984) that theorises an association between loving relationship pre-termination, and greater post-termination ambivalence and adjustment. A termination provides a pivotal crossroad type moment in an intimate relationship that can reinforce the desire to escape from an unappealing relationship. However, when this once unappealing relationship turns supportive, it has the potential to cause confused feelings for the intimate partner, as well as ambivalence concerning the termination itself (Robbins, 1984). Subsequent relationship cessations have the capacity to add to feelings of emancipation from the termination and the wish to have a better quality of life (Coleman, 2007). However, the findings from this thesis do not support the notion that termination led to the deterioration of feelings and the amplification of hostility and disgust towards their partner and men in general (Kolstad, 1957; Smith, 1973; Vincent, 1961).

In accordance with attachment theories, pregnancy termination can lead to 'attachment injury' within an intimate relationship. As noted by Coleman, Rueman and Spence (2006), this injury occurs when both partners view the unplanned pregnancy as being a 'crisis', and when there is a lack of open and respectful communication between the two. However, as was the case with some participants in this thesis, participants neither experienced nor regarded the termination as an 'injury'. When there was a discrepancy between the two individuals in the relationship, this allowed one partner to support the other emotionally. In most cases this involved the male partner. Attachment theories therefore posit that secure attachment styles, developed from childhood, translate positively to intimate relationships where a termination would have negligible, if any, effect on the relationship. Alternatively, an insecure attachment style, characterised by negative perceptions of self and fearfulness of rejection, may have the potential to exacerbate interpersonal difficulties within a relationship post-termination (Coleman, Rue & Spence, 2006).

Termination as crossroads: "I didn't want to be puking up the isle".

The termination represented a defining moment for many participants' relationships. It required them to consider and re-evaluate the circumstances,

quality, and future of their intimate relationship, and propelled them, often prematurely, to make a relationship-related decision. Some participants viewed this situation as a ‘crisis’, which led them to expect the support of their partner (Coleman, Rue & Spence, 2006).

The following table, Table 5, illustrates how an intimate relationship effected the decision to have a termination:

Table 5: Various ways in which a relationship effected the decision to have a termination.

	Relationship was not stable/long-lasting, or marriage as pre-requisite	Dissolved, new or unstable relationship	Partner as unappealing, or the “wrong guy” to have a child with	Partner cannot or will not support the participant and child	Not want to be a single mother
Isabelle	✓	✓			
Arietta	✓	✓	✓	✓	
Megan				✓	✓
Keisha		✓	✓		
Jenny	✓	✓	✓		
Rachel					

As can be seen in Table 5, there often are multiple partner-related reasons to explain why a participant might desire a termination (Trinh, 2012). This demonstrates that participants are mindful of the environment that they would hypothetically be bringing a child into and, ultimately, illustrates the significance of loving, unconditional, committed, and stable intimate relationships as a precursor for pregnancy (Trinh, 2012).

Many participants in this research cited partner-related characteristics or circumstances as being an important or prevailing reason for termination,

consistent with existing research (Chibber, Briggs, Roberts & Foster, 2013; Torres & Forest, 1998). Attending to these circumstances and reasons demonstrate women's ability to identify partner support and the overall quality of their relationship (Finer, Frohwirth, Dauphinee, Singh & Moore, 2006). Specifically, Chibber, Briggs, Roberts and Foster (2013) note that the most frequently cited reasons to terminate, owing to partner-related circumstances include dissolved, novel, or poor relationship (31% of women), a partner who will not or cannot support the women to have a baby (26%), a partner being the 'wrong guy' to have a relationship with (21%), the simultaneous desire to be married before pregnancy and not to be a 'single mother' (27%), and a partner did not want a child (10%). This thesis followed a similar pattern in terms of the various cited partner-related reasons for termination. Similar to existing research, when weighing up a pregnancy termination due to these reasons, participants in this thesis invariably evaluated whether this relationship was suitable and stable at the time that decisions were being made either to keep the child or to terminate the pregnancy (Foster, Jackson, Cosby, Weitz, Darney & Drey, 2008). Women therefore weigh up complexities, vulnerabilities, and reflect upon their lives and values as they seek empowerment in making the decision to terminate.

However, partner related characteristics were not always the sole reason for termination (Trinh, 2012). Other reasons noted by participants in my study included financial instability and unpreparedness, the desire for independence, the need for secrecy where the participant did not want their religious community or family to know about the pregnancy, and not wanting to have children. Participants therefore identified at least two reasons for termination, consistent with international research regarding reasons for termination (Santelli, Speizer, Avery & Kendall, 2006). This demonstrates that whilst partner characteristics are significant, there is usually another salient factor contributing to the decision-making process (Santelli, Speizer, Avery & Kendall, 2006).

The majority of participants included their intimate partner in the decision-making process, despite sometimes being in novel or unsatisfactory relationships. For these participants, the inclusion of their partner was never doubted or questioned and was seen as inevitable because the pregnancy involved both of them, and at

that time they were in an on-going relationship with one another. This contradicts research that suggests that women who make the decision to terminate their pregnancy are self-invested and tend not to inform the father (Tatum, Rueda, Bain, Clyde & Carino, 2012). Having a supportive partner, characterised by open communication and respect throughout the decision-making process, has been cited as being important factors for the longevity of the relationship (Norris et al., 2011). Alternatively, couples that disagree with the decision to terminate are more likely to experience increased conflict, to feel rejection or a lack of respect have decreased communication, and increased defensive attitudes (Naziri, 2007). The couple also may experience guilt and self-blame due to perceived suffering of one another (Naziri, 2007).

The following table, Table 6, demonstrates the extent to which participants in an intimate relationship at the time of the discovery of pregnancy encouraged their partners to be involved in the decision-making process. Rachel was the only participant who was not in a relationship at the time that her pregnancy was discovered.

Table 6: Participants who tried to involve their partner in termination decision-making.

	Participant tried, or succeeded, to involve their partner in pregnancy decision-making
Megan	✓
Arietta	✓
Jenny	✓
Isabelle	✓
Keisha	
Rachel	N/A

Clearly the women in this study actively considered the salience of relationship issues, or quality of life enjoyed by any previous children, rather than pursuing a termination purely for individual and personal reasons, a finding consistent with

Costescu and Lamont, (2013) and Hoggart (2012). This research suggests that a degree of consultation and seeking intimate partner contentment with the decision occurred. Previous research suggests that one-half of women had largely made their decision when it came time to inform their partner (Costescu & Lamont, 2013), and that a partner's role in decision-making is possibly more profound in those instances where the woman is ambivalent about whether or not to terminate the pregnancy (Costescu & Lamont, 2013). Interestingly, Costescu and Lamont (2013) discovered that approximately two thirds of women in their study viewed the decision-making as mutual whereas one quarter viewed it as being the women's choice, the remaining believing it to be their partner's choice. Evans (2001) and Hoggart (2012) also discovered a similar pattern.

The research literature concerning whether a partner has more influence over decision-making than other support networks, friends or family is ambivalent. As Tatum, Rueda, Bain, Clyde and Carino (2012) found that partners were no more influential than friends whereas Evans (2001) and Finken and Jacobs (1996) report that partners have a profound effect on decision-making. Evans (2001) notes that this effect was indirect, was often subconscious by participants, but that it swayed decision-making towards their partner's preference. To supplement this, Finken and Jacobs (1996) earlier observed that a hypothetical pregnancy scenario had resulted in women choosing their partner as their first person to confide in. However, this did not apply to hypothetical life scenarios that involved education or medical care (Finken & Jacobs, 1996). The findings of my study appear to sit between these polarised conclusions, possibly due to the small sample size, or different method used to obtain results.

Incongruent experiences: "I wanted this to be something we grow from but he was on a different level".

For some women who underwent a termination, this experience was incongruent with that of their partner, and resulted in either partner struggling emotionally (Robson, 2002). This can create tension, conflict, or misunderstandings between couples, especially when communication is stalled or absent, or when there is an absence of respectful interactions (Coleman, 2007).

The following table, Table 7, documents whether participants experienced a different experience pre-and post-termination compared with their intimate partner. For participants Keisha and Rachel, whilst they were not in an intimate relationship at the time of their terminations, a period of sustained contact in the immediate aftermath of the termination confirmed incongruent responses. As can be seen, all participants experienced incongruent responses to varying degrees; this can be in the form of feeling emotionally content and peaceful while their partner had difficulty coping emotionally, and vice versa. There was a 50:50 split between participants who coped better than their partners and partners who coped comparatively better than the participant.

Table 7: Incongruent responses pre- and post- termination and the comparison of participants versus partners in coping comparatively better.

Participants	Incongruent responses pre-termination	Incongruent responses post-termination	Participant coping comparatively better than partner	Partner coping comparatively better than participant
Arietta	✓	✓		✓
Jenny	✓	✓		✓
Megan	✓	✓	✓	
Isabelle	✓	✓		✓
Keisha	✓	✓	✓	
Rachel	✓	✓	✓	

For some participants, their difficulty in coping was exacerbated by their partner having been present at the termination clinic. In this instance, the partner's emotions made it difficult for the woman to manage her own emotions, as well as be there for her partner. In some cases this caused disagreement, resentment, and led participants to feel isolated when undergoing a highly personal experience. Regardless of whether their partner was coping better than the participant, both represented challenges for those who continued with their relationship at the time of termination, and in the immediate aftermath.

Robson (2002) argues that this may be related to different experiences of the termination and associated different gender-based reactions to grief. This was discovered due to be the tendency for men tend to react strongly during the circumstances of the termination on the day and then do not demonstrate any additional emotion. Robson (2002) claimed that the woman could feel isolated because her partner views the termination as a 'past event' and one that is no longer acceptable to discuss (Robson, 2002). This is particularly prominent in Western-based notions of grief, where grief has a time limit and is seldom discussed overtly or at length. Pakeha grief and death responses are markedly different from Māori where Māori recognise kinship and the need to celebrate life and mark death. Pakeha typically view grief and death in terms of a belief in the need to create additional 'distance' (Dansey, 1995). Pakeha can send flowers or believe that by leaving the griever alone they are respecting their privacy and autonomy (Dansey, 1995).

As noted by Klass (1997), the 'disenfranchised grief' as associated with pregnancy terminations often require partner validation of the grief to ensure intimacy, satisfaction, and sometimes the survival of the relationship 'Disenfranchised grief' refers to grief that is not acknowledged by society and, in the context of a termination, can result in each partner looking to the other to ascertain whether the grief should be shared. When this is not shared isolation, and indifference can occur within the intimate relationship (Klass, 1997).

Because women invariably are the ones who experience the termination directly, and are confronted with gender-based generalisations regarding grief, the resultant experience can often be viewed as being somehow unbalanced. If one's male partner does not express emotions overtly after the termination, whilst the woman does, this can lead to a sensation of wanting men to grieve in similar ways (Robson, 2002). In some cases, women may become frustrated that their partner's emotions are there, but remain suppressed, and interpret this as defiance, as avoiding any discussions concerning the termination, or feeling that the event is insignificant (Robson, 2002). Consequently, gender-based differences in grief may contribute towards unequal feelings or indifference in relationships. However, in some instances, men may feel a duty of care to support their partner

and this might coincide with their true feelings concerning the pregnancy (Robson, 2002).

Incongruent couples have been found to present a threat to relationship stability, especially in the absence of overt emotions (Nazaré, Fonseca, & Canavarro, 2012). A lack of overt manifestations may lead to interpretation of indifference and isolation, thereby exacerbating relationship conflicts (Casey, 2010). Couples who are able to recognise and accept that differences exist are more likely to engage in on-going communication in order to enhance overall relationship satisfaction (Nazaré, Fonseca, & Canavarro, 2012).

Some of the participants who were in relatively new relationships attempted to ignore any difficulties they were having in the immediate aftermath of the decision to terminate their pregnancies. Other participants appeared to use concealment as a way of enacting the social script for how young women *should* behave and feel following a termination (Robson, 2002). Participants were aware that while it was not abnormal to experience relief, they should also convey a sense of sadness as the predominant emotion. Moreover, this sadness should be balanced by not feeling guilt, regret, or anger because the decision to terminate is seen as one that removes the right to grieve (Klass, 1997). Owing to social stigma young women tend to confide in close family members and their intimate partner, thereby ensuring that the termination remained a secret event known only by a select few.

This thesis demonstrates that intimate partners' inability to control their emotions and to engage in effective coping mechanisms, both on the day of termination and in the aftermath, can have a detrimental impact upon young women. This correlates with other research that theorises that attachment theories, specifically positive models of self and others, leads to increased expectations for positive partner support (Cozzarelli, Sumer & Major, 1998). However, Cozzarelli, Sumer and Major (1998) further claim that self-esteem has the potential to mitigate the effect of partner's inability to cope, a finding that is not substantiated in more recent research (Bradshaw & Slade, 2003). When expectations for partner support are not met, young women are required to draw upon their own coping resources

and to provide these for their partner (Bradshaw & Slade, 2003). As discovered in this thesis, learning about intimate partner's emotions and true feelings on the day of termination, led to feelings of resentment about their partner's inability to communicate openly and honestly. Coyle, Coleman and Rue (2010) note that positive pre-termination counselling can mitigate feelings of resentment, particularly when the pregnancy is viewed as a 'crisis' and incongruence is present in the relationship.

Further research has suggested that prior support in the lead-up to the termination is a good predictor of wellbeing following the termination (Major, Cooper, Zubeck, Cozzarelli, & Richards, 1997). However this finding was not substantiated through the participant's narratives discussed in this thesis. Some of the narratives in this thesis research also suggest partners' ability to provide support changed following the termination, in either a positive or a negative way. Research by Major et al (1997) suggests that positive partner interactions can protect women from stressful experiences. Particular aspects of partner intimacy, including validation and acceptance, allowed for the active exchange of experiences and feelings (Moreira, Amaral & Canavarro, 2009). The perception of support from one's partner also has been associated with less intense emotions following a termination and more adaptive and positive reactions to grief (Casey, 2008).

Consistent with the international literature, participants whose partners were present at the termination clinic experienced very mixed emotions (Major, Mueller & Hildebrandt, 1985). Having their partner present on the day of termination made the experience all the more stressful, particularly for participants Megan, Isabelle, and Arietta because their partners' emotions triggered or furthered their own emotional responses to the termination (Major, Mueller, & Hildebrandt, 1985). As Naziri (2007) has observed, intimate partner emotions and feelings frequently can have a negative impact on the experience of young women's terminations. This occurs through male partner maladaptive coping strategies, exemplified by feeling guilt, regret, or a sense of responsibility for having caused the woman to undergo this procedure (Naziri, 2007). This, in

turn, can lead intimate partners to compensate by becoming increasingly intrusive in an attempt to control the situation (Naziri, 2007).

The expression of emotion by the participant's partners led to confusion and suspicion concerning their partner's views on termination. It also was a pivotal moment in that it cemented the recognition that this decision would, in some ways, have a significant impact on their partner's life. Partner's reactions did impact on women's overall experience of a termination and caused additional stress on the day, resulting in feelings of anger and frustration (Major, Mueller & Hildebrandt, 1985). Identifying and evaluating the pre-existing qualities and patterns of the relationship prior to termination for the participant in this thesis research revealed that, in Jenny's case, the absence of her indifferent partner on the day of the procedure combined with perceived support afterwards, in fact helped to prolong the course of their relationship.

Concealment in future relationships: "If I could reveal all of me... it would be amazing".

As pregnancy terminations still are a source of considerable social censure, women can carry these negative perceptions forward into future intimate relationships (Astbury-Ward, Parry & Carnwell, 2012). Accordingly, many women actively conceal their termination in order to avoid a negative reaction and subsequent relationship conflicts (Astbury-Ward, Parry & Carnwell, 2012). Women may reason that the cost of confessing their termination experience, regardless of whether they know their partner's views, is simply too risky. This occurs despite some women wanting to reveal their experience so as to enhance intimacy and satisfaction, and to have a completely honest 'no secrets' approach to their intimate relationship (Astbury-Ward, Parry & Carnwell, 2012). In some cases, suppressing this experience from one's partner can lead to a heightened sense of fear, isolation, and validate the feelings of the termination as being 'wrong' (Astbury-Ward, Parry, & Carnwell, 2012). Conversely, disclosing one's termination to a future partner might ease the sense of self-blame and provide an opportunity for the woman to discover her feelings about other emotional or controversial issues.

The following table, Table 8, identifies those participants who chose to conceal their termination in future relationships. For Isabelle, ‘N/A’ (Not Applicable) has been recorded because she has remained in the same relationship since termination. As demonstrated below, there appears to be a relatively even split between those who opted to conceal and those who admitted their previous termination

Table 8: Participants who concealed their termination in future relationships.

Participants	Concealed the termination for future partners
Megan	
Isabelle	N/A
Rachel	
Keisha	✓
Arietta	✓
Jenny	✓

Participants who chose not to reveal their termination history to their post-termination partner, had a genuine fear of their partner’s reaction and the wish to consign this event to their past. For many women who have undergone a termination, the experience was immensely private. While some viewed it as ‘irrelevant’ and ‘unnecessary’, others were actively aware of the risk of negative and highly emotional reactions (Kumar, Hessini & Mitchell, 2009). For some participants having omitted to tell their (new) partners created a sense of heightened anxiety were it ever to come out from either a family member or a health professional.

Those participants who did reveal their termination experienced enhanced intimacy within their relationship. Sharing similar views on termination helped to provide either a sense of freedom from the experience or a sense of comfortability in having sexual encounters. For some participants, communicating to a post-termination partner about their experience led to heightened appreciation, trust, and respect for the partner. In marked contrast to other research, into terminations

this thesis did not specifically examine the hypothesis that terminations lead to ‘sexual dysfunction’ and that the termination increases anxiety in future relationships (Barnett, Freudenberg & Wille, 1992; Coleman, Rue & Coyle, 2010; Fok, Siu & Lau, 2005). These researchers regard this reduction as providing clear support for the psychological theory of terminations whereby terminations commonly are associated with adverse mental health implications. Wing, Clance, Burge-Callaway and Armistead (2001), associate sexual dysfunction with the fear of pregnancy, connect sex with the previous conception, and feeling unworthy of one’s partner.

Previous research has indicated that pregnancy terminations, whether communicated openly or not, are associated with an escalation in conflict, more frequent disagreements about finances, children, and jealousy (Coleman, Rue & Spence, 2006). Instead, this thesis reveals that women make active efforts to weigh up the advantages and disadvantages of revealing the termination as a means of self-protection.

Part II: Quality of Care: Expectations and preferences versus reality

This section discusses participant’s perception of the quality of care they received. Quality of care has been found to have a considerable impact on the overall experience of pregnancy terminations both in terms of the international literature (Silva & McNeill, 2011), and the experiences of the participants in this thesis research.

Getting a foot in the door: “Okay, now what do I do?”.

‘Getting a foot in the door’ refers to the initial stages where an organisation’s infrastructure can make access to termination difficult. At the individual level, particular health professionals hold a considerable degree of authority and prestige in society by virtue of the cultural and professional expectation that these people are the sources of specialized knowledge and are able to advocate for their patients (Purdy, 2006). Authority can also be understood in terms of power relations, material resources, and knowledge. Although it can appear to be a

reasonably neutral concept authority has the potential to be used or abused (Goodyear-Smith & Buetow, 2001). Pappas (1990) has noted, a person's authority gain does not necessarily mean an individual's loss, in terms of knowledge because both can benefit from the interaction. Whilst it is rare to have an interaction that involves equality of authority, the greater the discrepancy of authority, the greater the possibility of abuse in the relationship (Pappas, 1990).

The following table, Table 9, identifies the participants who experienced difficulty in gaining access to a termination service. Included are those participants who already knew the doctor who they initially had consulted as well as those who had to organise the appointments themselves.

Table 9: 'Getting in the door' related issues including participants contact with doctor or knowledge of health professional, and whether this appointment was organised themselves.

Participants	Participants had difficulty 'getting a foot in the door'	Participant contacted a doctor for their initial consult	Participants knew of the health professional of whom they initially consulted	Participants organised this appointment themselves (without support)
Megan		✓	✓	✓
Isabelle		✓	✓	✓
Rachel (1 st experience)	✓	✓	✓	✓
Rachel (2 nd experience)		✓	✓	✓
Keisha		✓		
Jenny	✓	✓		✓
Arietta	✓	✓		✓

As indicated in Table 9, participants are divided as to whether they experienced difficulty 'getting a foot in the door'. Those who experienced little difficulty in

achieving initial access, accessed a doctor they knew who agreed to provide them with a referral. For Keisha, having a cousin who had been through the termination system meant that not only was she able to take control of Keisha's appointments but also she had knowledge of those health professionals who would agree to refer Keisha for a termination.

The literature concerning doctor-patient interaction has outlined models concerning the locus of autonomy and decision-making (Charles & Whelan, 1999). The doctor might make decisions without patient participation or, input, or make decisions based on the patient's perceived desires or needs, or the doctor might offer information to the patient to enable the patient to become the sole decision-maker (Charles & Whelan, 1999). While there are variations between these models – for example, including shared decision-making - most often when a doctor (or health professional in authority) is aware of patient desires, shares in decision-making, and informs the patient in full, the relationship greatly favours the doctor (Goodyear-Smith & Buetow, 2001).

Because doctors and surgeons enjoy the highest level of authority amongst health professionals they are conceptualised as experts (Purdy, 2001; 2006). Given this reality, and the fact that doctors are the licensed providers of terminations under New Zealand law, this invariably results in a very unequal power balance between doctors and women desiring a termination (Purdy, 2006). There is an obvious tension because reproductive autonomy is imperative to women's welfare because child bearing requires women's bodies but they share unequal responsibility in terms of child-rearing (Purdy, 2006). The removal of external constraints for termination decision-making fosters opportunities for authentic autonomy (Goodyear-Smith and Buetow, 2001; Sawicki, 1991).

At the time of writing, the current New Zealand pregnancy termination legislation and New Zealand Medical Council guidelines permit doctors to deny terminations to women seeking this procedure. Tentatively, this refusal can take two different forms: first, doctors might refuse to refer women to another doctor (who may ethically approve a termination) and second, doctors can use their medical judgement to determine that a woman does not satisfy the legal requirements for a

termination; for example, termination on the grounds of rape, incest, or danger to physical or mental health of woman. St George (2013) has noted:

There are rare occasions when a doctor does not wish to discuss a particular treatment with a patient because that treatment conflicts with the values or beliefs of the doctor. An example of this might be termination of pregnancy. In this case the doctor must inform the patient of this conflict and refer the patient forthwith to a doctor who can discuss all the currently recommended and accepted treatment options (p. 98).

These provisions are outlined further in the Health Practitioners Competence Assurance Act (2003) whereby a health professional can refuse to provide a patient with the means to access a termination. A High Court ruling in 2010 also stated that a doctor is obliged to inform the woman of another health practitioner or Family Planning Clinic who can provide assistance (McMillan, 2010). The relevant professions involved in provision of pregnancy terminations are clearly specified in the Health Practitioners Competence Assurance Act (2003): midwife, sonographers, nurses, occupational therapists, pharmacists, psychologists, and psychotherapists (Ministry of Health, 2015).

Obligations under this legislation are important, particularly because doctors in private practice frequently are the gatekeepers regarding terminations of pregnancy (Purdy, 2006). The reality that doctors were the gatekeepers for accessing terminations was further supported through the participant's narratives in this research, all of whom first visited a doctor rather than a nurse, counsellor, or local Family Planning Clinic. When women are denied the right of referral it likely hinders their coping resources, disempowers them, and discourages them from attempting to enter the system again (Purdy, 2006). Unfortunately, some participants had observed, some doctors who were opposed to the decision to terminate did not refer participants to another provider, and acted in a manner that hindered their wellbeing and their subsequent experience of the service.

Accessibility challenges: “something more to worry about”.

Accessibility is a complex concept because the various ways whereby a population gains access to healthcare is highly dependent on financial, cultural, social, or organisational barriers (Guilliford, Figueroa-Munoz, Myfanway, Hughes, Gibson, Beech & Hudson, 2002). Any consideration of accessibility, Guildford et al (2002) argue also needs to pay special attention to individuals’ different health needs, their material and cultural circumstances, and their personal perspectives.

All participants experienced accessibility challenges in the lead up to their pregnancy termination. These challenges included financial constraints, the presence of anti-termination protestors, associated travel costs and travel time, the availability of childcare, the waiting room atmosphere, and the timely delivery of services.

The following table, Table 10, identifies some of the barriers that can hinder women’s access to a pregnancy termination. As discussed earlier, many participants were reliant on others for transport, often because of their geographical distance from the termination centre. Access in this sense required the availability of a car or other transport, and/or involved having sufficient financial resources to cover costs (Guilliford, et al., 2002). Not all participants had to pay for accommodation costs because some were able to stay with family or lived within a reasonably close proximity to their termination provider, one of the participants had to contend with the presence of protestors, and only one participant had difficulty organising childcare.

Table 10: Participants who experienced various forms of accessibility issues.

	Had to ask friends/family for a car/travel money	Transport costs	Accommodation costs	Presence of protestors	Childcare difficulties

Megan					N/A
Isabelle	✓				N/A
Jenny	✓	✓	✓	✓	N/A
Rachel	✓	✓	✓		✓
Keisha	✓	✓			
Arietta	✓		✓		N/A

The timeliness of the various stages to receive a termination, as well as timeliness on the day of termination, are important components in terms of accessibility (Silva & McNeill, 2011). Consideration for whether time had to be taken off for work or study also is important, as participants might have forthcoming assignments, or have no annual leave left. The waiting room atmosphere can provide a further accessibility barrier in that a negative and uncomfortable atmosphere might leave participants feeling unable to proceed with a desired termination (Purdy, 2006).

The following table, Table 11, identifies those participants who experienced specific accessibility barriers.

Table 11: Participants who experienced further accessibility issues in the termination service.

	Travelling time to clinic	Time taken off work/study	Time delays at clinic	Time delays across service (2 weeks +)	Negative waiting room atmosphere
Megan	< 15 minutes	✓	✓	✓	✓
Isabelle	40 minutes		✓		✓
Jenny	3 hours 10 minutes	✓	✓	✓	✓
Rachel	2 hours 45 minutes	N/A			

Keisha	1 hour 45 minutes	N/A		N/A	✓
Arietta	2 hours	✓	✓	✓	✓

It is important to note here that the Abortion Supervisory Committee (2009) recommended a wait time of no longer than two weeks from the time of referral to the time of procedure. For three participants (Megan, Jenny and Arietta), this timeframe was not met. Five participants also had to travel to a termination clinic that was located outside their town or city. This journey is consistent with research by Silva and McNeill (2008) who noted that women obtaining a termination away from their local town had an average return journey of 442 kilometres. Assuming that participants were travelling on the open road at the open road speed limit (100km/hour) with minimal traffic delays or diversions, this would take between four and five hours.

As Silva and McNeill (2008) discovered, participants from the three New Zealand centres of proportionately higher Māori populations (for example, Gisborne, Hawkes Bay, and Manawatu-Wanganui) were required to travel the longest distance. This is consistent with the experiences of Arietta, a young Māori participant, who was required to travel some distance to Wellington and presents an additional barrier to an already disadvantaged population (Silva & McNeill, 2008). As part of New Zealand's commitment and obligation under the Treaty of Waitangi, it is imperative that health disparities in termination settings are addressed through the widespread availability and accessibility of local termination. When this is not possible or practical, owing to limitations in resources then all reasonable travel and accommodation costs should be reimbursed.

Furthermore, owing to the decision of participants to have a termination at a public hospital, the social worker, sonographer, doctors' appointments, and the procedure itself was free of charge under the current maternity care provisions in New Zealand. This is a significant factor in increasing accessibility, particularly for young women who are more sensitive to changes in the economic cost of a termination (Garbacz, 1990; Jewell & Brown, 2000).

Recognising that economic cost is a real and significant barrier to women seeking a pregnancy termination, some centres in the United States use medication to induce termination rather than surgical means, as one way to provide easier access to terminations (Creinin & Vittinghoff, 1994; Henshaw, 1995). However in New Zealand, medication-induced terminations are available only up until nine weeks gestation, meaning that delays in decision-making or timeliness of the service will reduce termination options (Family Planning, 2015). For the participants in this thesis, all received a surgical termination by the time of decision-making and/or the availability of a termination appointment.

Accessibility in terms of how long it takes for a woman to find and to be approved by an authorised termination provider is dependent on how often the termination service is open, what their caseload is, and the time it takes from the initial referral, to approval, and then to termination (Henshaw, 1995). Moreover, 53 per cent of participants noted in Silva, McNeill and Ashton's (2011) research study felt that this wait was too long. These researchers further found that the earlier in pregnancy a woman enters the service then the longer she waits to obtain a termination. These findings clearly reveal that women's personal decision-making had little bearing or influence on these delays (Silva, McNeill & Ashton, 2011).

This finding is consistent with this thesis research in that one-half of the participants were unsatisfied with the length of time they were required to wait. For Rachel's first encounter with the termination service, in the mid-1990s was complicated and delayed owing to her involvement with mental health services and this meant that it became too late to terminate the pregnancy legally, despite Rachel's persistent and repeated requests for a termination. Rachel's second interaction with the service however, was more positive. For Keisha, as she had a court case to attend, this delayed her access to the termination. These delays or, in Rachel's case, inaccessibility to terminations, led to terminations occurring later in the pregnancy (Silva & McNeill, 2010).

There has been some improvement in reducing the average gestation time since 2006. In 2014, 57 per cent of terminations occurred before the tenth week compared with 36 per cent in 2006 (Statistics New Zealand, 2014). However, 43

per cent of terminations are still occurring beyond ten weeks, a fact that has been associated with an increased likelihood of subsequent negative psychological or physical complications (Silva, McNeill & Ashton, 2011). It is important to note that an international comparison here initially seem relevant but researchers have argued that statistics would be meaningless, given the different services available in each of the states, the different referral pathways, and organisational structure of the clinics (Silva & McNeill, 2010).

More recently in New Zealand a certified termination consultant established an initiative in an effort to reduce waiting times (Johnston, 2015). At the time of writing, a telephone number 0800 ABORTION was created and two certified consultants were employed who could assess women's eligibility for a pregnancy termination. Callers can expect to be contacted within 24 hours concerning scheduling appointments for a doctor (for swabs and blood tests) and sonographer (Johnston, 2015). This initiative seeks to prevent delays, thereby reducing the number of links in the chain in the process of obtaining a termination. Because this service is relatively new, at the time of writing there are no statistics available regarding the satisfaction, or efficiency of, this service.

(Un) expected waiting times on the day of the termination have the potential to form a barrier to access. This can be the result of pregnancy-related symptoms such as tiredness and morning sickness, the cost of hospital parking, anxiety experienced while waiting in a sterile waiting room, or other personal barriers. Miceli and Wolosin (2004) have discovered that although longer waiting times are associated with overall dissatisfaction with the quality of care, this can be mediated by good communication and rapport between the practitioner and patient (Miceli & Wolosin, 2004). Becker and Douglas (2008) have investigated this phenomenon further and found that dissatisfaction can be reduced significantly by various ways to be occupied during this postponement.

Participants in this thesis study experienced waiting times that required them to be present from early morning until late in the afternoon (an average of five hours), and some were unprepared for this wait. Taylor (1994) has noted that unexpected waiting times can create, if not exacerbate feelings of uncertainty, irritability,

stress, and anger. Providing a range of activities to the patient allowed them to self-regulate and led to reduced levels of stress or anxiety (Becker & Douglass, 2008). Patients also may associate the care provided in the physical environment with the care they expect from their practitioner (Arneil & Devlin, 2002). Despite the fact that participants were required to remain at the clinic for the majority of the day, some participants still felt rushed by the time they had joined the queue. This waiting period (known as preprocess) has been identified as being an important indicator of quality of care and it can heighten anxiety or frustration, as there appears to be limited (if any) progress moving forward through the queue (Arneil & Devlin, 2002). Participants found that having to wait all day at the clinic with others was not only physically and emotionally tiring but also awkward and occasionally, embarrassing for many participants.

Through focus group research conducted by Anderson, Camacho and Balkrishnan (2007) waiting rooms were viewed much more positively when they were 'homely', had reading material, curtains, were warm, had tea and coffee facilities, played uplifting music, and had comfortable seats. Arneil and Devli (2002) recommended that waiting rooms should be designed so that the seating arrangement ensured a greater degree of personal space, privacy, and sophistication (Arneil & Devli, 2002). Becker and Douglas (2008) also argue that the waiting room environment is a significant contributor towards perceptions of quality of care and patients' overall experience in the health system. This desire is likely to be amplified in the context of terminations, owing to possible anxiety or stress.

Waiting long periods before seeing a doctor can be offset by the perception of having a reasonable period of time face-to-face with the practitioner (Anderson, Camacho, & Balkrishnan, 2007). Research has demonstrated that individuals who experience long wait times with a shortened appointment with their doctors have produced the lowest level of satisfaction (Anderson, Camacho & Balkrishnan, 2007). In other words, patients are likely to feel negatively about the service because the time they invested in waiting for the service was a poor trade-off in terms of their overall experience (Anderson, Camacho & Balkrishnan, 2007). Having to wait for long periods in a populated communal waiting room with

relatively brief interactions with health professionals was experienced by four participants in this study- Megan, Arietta, Jenny and Rachel.

Working the system: “they can say no”.

Working the system refers not only to the authority that doctors, and other health professionals have in the provision of pregnancy termination services (Leslie, 2010) but also refers to conscious actions that women make in order to obtain a legal pregnancy termination. Working the system required an awareness of authority and social stigma, and was easier for those participants who had prior exposure to terminations (East, 1999).

The following table, Table 12, demonstrates which participants engaged in working the system and how this was enacted.

Table 12: Participants who 'worked the system' and through what means.

Participants	Engaged in 'working the system'?	How was 'working the system' achieved?
Arietta	✓	Participated in inaccurate rationale for termination and self- researched information
Megan		
Isabelle	✓	Concealment and composure of emotions
Keisha		
Jenny	✓	Composure and Concealment
Rachel (1 st occasion)		
Rachel (2nd occasion)	✓	Stronger and firmer 'voice' in system

As summarised in the table above, those participants who engaged in working the system did so using a range of strategies. Participants either concealed their emotions, composed themselves in front of health professionals (in order to follow the ‘social script’ for terminations), or participated in giving an acceptable (but inaccurate) rationale for their termination. Alternative ways in which participants worked the system included familiarising themselves with research in order to question information provided by doctors. Having a strong and firm ‘voice’ in the process as well as being able to confidently articulate reasons for termination, was a further mechanism adopted in ‘working the system’.

The shift in social censure and discourse for women receiving terminations from being viewed as ‘selfish’ to ‘desperate’ occurred alongside a changing discourse claiming that terminations were psychologically harmful (Leslie, 2010). This occurred despite the prevalence of contemporary literature revealing that the association between termination and mental health was, at best, minimal (Fergusson, Horwood & Ridder, 2006). With the passage of time, and the introduction of terminations being able to be performed legally on mental health grounds, women’s accessibility to pregnancy terminations increased (Leslie, 2010). Nevertheless, working the system required women to provide a rationale for termination, on the grounds of danger to their mental health, and this provision excluded any relevant social reasons and arguably perpetuated social censure (Astbury-Ward, Parry, & Carnwell, 2012; Leslie, 2010).

Social stigma has the potential to effect self-esteem, especially for women contemplating pregnancy terminations (Astbury-Ward, Parry, & Carnwell, 2012; Leslie, 2010). Psychosocial theories, such as those of Cooley (1956), posit that self-concept develops from interactions with others and is partially reflective of other’s appraisals. Self-esteem and self-concept necessitate an awareness and adoption of people’s appraisals (Crocker & Major, 1989). An alternate model of self-esteem is efficacy-based, and claims that by being in control of the environment, one retains a sense of competency, fulfillment, and ultimately self-esteem (Crocker & Major, 1989). However, attributing factors to the external environment rather than internal reasons is likely to protect self-esteem (Tesser, Millar, & Moore, 1988). Participants in this thesis research similarly tended to

stigmatise the group of women who receive terminations rather than themselves personally. The difficulty that arises for these participants is that by arriving at a rationale that is so markedly different from their situation, feelings of frustration, stress, or sadness could be induced.

Some participants found themselves metaphorically putting on a 'mask' to cover their emotions when they talked with health professionals. They wanted to appear 'normal' and to follow appropriate patterns of behaviour (Astbury-Ward, Parry, & Carnwell, 2012; Leslie, 2010). This contributed towards a more stressful day for some participants because they knew the doctor was an authority figure who officially could grant or decline a termination (Abortion Supervisory Committee, 2008). This can be done when the doctor perceives the patient to be ambivalent, under undue pressure, or when the doctor has grounds to believe that a patient's mental health will suffer as a consequence of a termination (Abortion services, 2013).

Some participants therefore were required to 'work the system' despite having depleted emotional and coping resources. To date there is very limited research into the effects of 'working the system' to 'mask' or conceal overwhelming or conflicting emotions when in the presence of health professional staff. Perhaps normalising and validating these feelings in the counselling forum might provide participants with specific coping strategies for this situation and increase their confidence and certainty of being able to access a termination.

Medicalisation and "Revolving doors".

Medicalisation in women's health care refers to the tendency to conceptualise normal events in women's lives such as pregnancy, menstruation, and termination as pathological and in need of medical attention (Grady, 1999; Purdy, 2001). Medical language is used to describe and understand a situation, and a medical intervention is used to rectify any problems that are identified (Conrad, 1992; Purdy, 2001). Medicalisation can occur at three levels: conceptual, organisational, and at the level of doctor-patient communication (Conrad & Schneider, 1980). There are notable discrepancies surrounding the doctor-patient interaction owing

to cultural expectations of what it means to be a 'doctor'. These discrepancies can be exemplified by how the doctor dresses (formally or informally), how they expect to be addressed (by first name or by the title 'doctor'), and can have an impact on the patient's level of comfort (Halfmann, 2011).

Revolving doors also refers to simultaneous feelings of homogenized and clinical care with the patient perceiving themselves simply as a number rather than as an individual with unique needs and preferences. When patients present for termination it is imperative that health professionals strive to acknowledge relevant cultural, social, financial and personal needs (Paul, Lichtenberg & Borgatta, 2009). Consistent with research by Anderson, Barbara, Weisman, Hudson-Schoelle, Binko, Schneider, Freund and Gwinner (2001), women tend to view health care in more holistic terms, involving physical, mental and emotional wellbeing. Notions of women's' health also included being educated about available contraception, sexuality, family problems, difficulties in managing child-rearing, domestic violence, and alternative medicine (Anderson et al., 2001).

In Halfmann's (2011) analysis of the medicalization of pregnancy terminations in the United States of America, various discourses, practices, and identities were discovered. Halfmann (2011) found that terminations were viewed as medicalised due to the hospital setting in which they primarily are based (rather than in free-standing clinics), the doctor's ability to authorise a termination, and the grounds for authorising a termination – e.g., fetal abnormality, danger to physical or mental health (Halfmann, 2011; Purdy, 2006). The same findings apply to New Zealand where licensed doctors have the authority to refer or decline a termination on medical grounds (Silva & McNeill, 2010).

The provision of culturally appropriate services is significant and will likely lead to enhanced patient trust, communication, and satisfaction with their experience (Betancourt, Green & Carrillo, 2002). Health professionals are able to enhance their competency by engaging in critical self-reflexivity to explore (and to fill) gaps in their knowledge, increase their exposure to other cultures, and to have greater awareness of the impact of their own belief systems (Nagata, 2004). This

self-directed mindfulness encourages being in the moment, subsequently changing our demeanour or behaviour when circumstances dictate (Nagata, 2004).

The following table, Table 13, indicates which participants experienced 'revolving doors' and whether they perceived this negatively.

Table 13: Participants who experienced 'revolving doors', 'medicalisation', and whether this was viewed negatively by participants.

	Experienced 'revolving doors'	Experienced 'medicalisation'	Did the participant perceive this negatively?
Arietta	✓	✓	✓
Megan	✓	✓	✓
Isabelle			
Keisha	✓	✓	✓
Rachel	✓	✓	
Jenny	✓	✓	✓

As this table shows, the majority of participants (five) experienced revolving doors and medicalisation in a pregnancy termination setting. Therefore, while most participants experienced a strong degree of medicalisation, this was not necessarily a negative encounter because, for some participants this suited their conceptualization of the experience of a termination. Participants who experienced neutral emotions on the day of the procedure, and who were not in an intimate relationship, generally were satisfied with a medicalised approach to their termination. As noted by Donaldson (2001), conceptions surrounding the suitability of the medicalization approach are dependent on the goal alignment between the practitioner and/or organisation, and the patient. This alignment allowed for individualized care within the termination setting, providing women with enhanced wellbeing and contentment (Purdy, 2006). Participants also appreciated the clinical inclusion of contraception knowledge and its provision on the day of termination which was found to be beneficial particularly for socially

disadvantaged populations, and as a contribution towards young women's wellbeing (Bajos, Lamarche-Vadel, Gilbert, Ferrand & Moreau, 2006; Nobili, Piergrossi, Brusati & Moja, 2007).

For Māori participants, culturally appropriate and tailored services are imperative to their wellbeing. The quality and provision of these services inevitably will impact upon Māori perceptions of quality of care in health care settings, thereby influencing their overall experience (Le Grice, 2014). Knowledge of various taboos and preferences (for example, Te Puke, the pubic area, for Māori women can be viewed as needing to be protected and not exposed) can enhance wellbeing (Rimene, Hassan, & Broughton, 1998). Understanding *tikanga* surrounding Māori women's reproduction will enhance rapport and facilitate wellbeing. However, engaging with Māori women will sometimes reveal a diversity of responses. This is due to Maori gradually adapting and integrating their beliefs to modern society (Le Grice, 2014). For Māori women who are immersed in *tikanga*, prayers (*karakia*) may be needed following the termination because the spirit (*wairua*) from conception had not been brought fully to term (Smith, 2009). This can involve active participation by a local Māori elder upon burial and return of the remains to the land (Smith, 2009).

As Pere (1994) has observed, traditionally the placenta (whenua) is buried in a special place where it will not be disturbed. In more advanced pregnancies the umbilical cord (*pito*) can also be buried in a cliff or tree (Pere, 1994). For the two Māori participants, Keisha and Arietta knew that returning the placenta to the land was a necessity. For Keisha this became a source of worry. Keisha's concern about protocol and reconnecting with her identity and belief systems might well have been eased had a health professional provided her with more guidance and support.

For Arietta, the counselling experience was mixed with competing assumptions about her cultural identity. Arietta initially was assumed to be Pakeha and had her name mispronounced presumably due to her lighter complexion and Pakeha sounding name that led to a juxtaposition of 'looking' Māori with 'being' Māori. This resulted in a heightened sense of unease whereby Arietta's pride (*mana*) was

damaged, leading her to seek to rectify her position as a Māori woman (*wahine*). Arietta felt that this would have been remedied more easily by self-reflexivity and an initial introduction, encouraging one another to share their cultural identification. For some young women, presenting themselves for a termination appointment can be fraught with stress that might manifest in shyness or appearing to be withdrawn (Henshaw, 1995).

Continuity of care has long been recognized as an essential element of quality of care and patient wellbeing (Donaldson, 2001). Donaldson (2001) has defined the “existence of some thread, individual, practitioner, group, or medical record that bind together episodes of care” (p.1). Continuity of care is related to revolving doors because the latter encompasses a process involving many individuals. In particular, participants Jenny and Arietta felt that being passed from provider to provider affected their termination experience. In this sense, there was no continuity of care and both Jenny and Arietta were required to visit multiple health professionals before receiving their terminations. Having to see so many health professionals required a lot of energy and repetition of their narrative in order to convince each professional about their decision to terminate. Alternatively, having one consistent supportive health professional throughout might not only have reduced stress but also provided much needed patient-centered care.

Participants also experienced medicalisation through the setting of their care. In this sense, transgressing time and space to the waiting room provided further testimony of the medicalisation processes (Warin, Baum, Kalucy, Murray, & Veale, 2000). Participants were required to sit in a designated waiting room area and are not permitted to move beyond this space. This effectively constructs the boundaries between the medical professional and the patient and can also be seen as a way to manage the demands on the system and to define appropriate periods for interaction (Warin et al., 2000). The perception of having more time or an appropriate length of time with health practitioners, leads towards feelings of satisfaction with the service. Unfortunately, for some participants, long waiting times in a ‘cold’ waiting room, followed by relative ‘timely’ procedure, was an uncomfortable experience.

Undeniably pregnancy terminations, by the nature of the procedure, are at least partly a medical issue (Treichler, 1990). However, by taking into consideration women's roles, responsibilities, and social context, practitioners can offer greater quality of care in terms of greater exposure and understanding of broader social constraints and enhanced empathy throughout the termination appointments (Purdy, 2001). By adjusting the culture of medicine in women's health care settings, for example, with pregnancy termination, holistic understandings of the relationship between social contexts and well-being can be appreciated and understood more fully (Halfmann, 2011; Purdy, 2001).

Tangibility: “You have nothing from it”.

Tangibility as a theme in this context refers to the invisible gain from the termination experience, primarily in terms of freedom from the constraints associated with pregnancy. These constraints include the need to contemplate accommodating a child as well as financial and social constraints. A notable social constraint includes the contact between intimate partners that would be continued were the pregnancy to be continued. This theme simultaneously includes the desire of tangibility linked with the invisible gains from the termination. Some participants experienced a strong sense of ‘nothingness’ following their termination because nothing tangible had been given. This desire for tangibility was strengthened in the months following the termination.

The following table, Table 14, represents the participants who simultaneously experienced invisible gains and a desire for tangibility:

Table 14: Participants who experienced 'invisible gains', desired tangibility and those who achieved this tangibility.

	Feelings of invisible gains	Desire for tangibility	Achieved tangibility in some form
Megan	✓	✓	✓
Isabelle	✓	✓	
Jenny	✓	✓	

Keisha		✓	✓
Arietta	✓	✓	✓
Rachel			

Most of the participants associated feelings of invisible gains with the desire for tangibility. For Keisha, as she received the pregnancy remains and was able to avoid her abuser (another tangible phenomenon), she had tangible gains arising from the termination. The ability to achieve tangibility was made possible by taking the pregnancy remains and burying them, obtaining the ultrasound image, and keeping various other items such as pamphlets, pregnancy tests, and hospital bracelets.

Women who decide to terminate their pregnancy can experience disenfranchised grief, which may or may not have been expected. Disenfranchised grief refers to grief that is not recognised by society and might involve a death of something or someone that is not recognised as a person. This grief often is not recognised because people were unaware of the bond, or because society does not accept that bond (Kumar, Hessinia & Mitchell, 2009). The secrecy of the termination is a function of pervasive stigma, and women therefore protect themselves from negative feedback, often remaining silent about the reality of their experience (Coleman, Rue, & Spence, 2006). Whilst there is a prevalence of research concerning grief for terminations due to fetal abnormality, there is a notable absence of literature for those women who have had a termination for other reasons (Korenromp, Christiaens, Van den Bout, Mulder, Hunfeld, Bilardo, Offermans & Visser, 2005). The very nature of this disenfranchised grief can lead towards feelings of wanting to counter-act this by having (and keeping) a tangible item or items (Mannion, 1994). This helps to remind women that the experience was in fact real, and provides evidence and permission to grieve in a more public form than was socially acceptable (Mannion, 1994). Researchers also have discovered that up to 61 per cent of women have existential beliefs surrounding terminations and approximately 50 per cent wanted a special act to recognise their termination (Stålhandske, Makenzius, Tydén & Larsson, 2012). Such existential beliefs have the potential to cause difficulty in adjusting after the termination, particularly when cultural or personal provisions are not forthcoming.

Having tangible ‘proof’ of the experience/pregnancy therefore can lead to acknowledgement of the experience, and the opportunity to accept this and move forward (Mannion, 1994). A physical site or object can provide a sense of peace, providing the opportunity spatially to re-visit if, or when appropriate (Mannion, 1994). Robson (2002) discovered that physical keepsakes such as wristbands and ultrasound scans can become useful in the grief process and can be examined on those occasions when disenfranchised grief reappears. Whilst many view decisions such as taking the remains for burial as overwhelming, some women express a sense of profound regret for not having done so or not having had the opportunity for a private funeral, especially for later term gestations (Robson, 2002).

The process of turning a stigmatized experience into something tangible was not discussed during the counselling process, possibly because of the time constraints that counsellors have with termination patients. Alternatively, the process of memorialising might not have been deemed important by each counsellor for the particular participants because, at that time, the woman was certain about her decision to terminate.

Mediating factors

In analysing the bi-directional relationship of pregnancy terminations with current and future relationships, along with the experience of quality of care, there appeared to be strong mediators between these phenomena for the participants in this thesis research. In particular, the strength of association with individuals who underwent a termination, pro-choice attitudes, and interrelated conception of the fetus are important. This aligns with international research conducted internationally, relating to the experience of termination (Coleman, Rue & Spence, 2006).

Pro-choice affiliation.

Most participants identified with the right of women to choose whether or not to terminate. This emphasizes the right of women to be able to control their fertility and to choose termination (Coleman, Rue & Spence, 2006). Furthermore, pro-

choice advocates argue that individuals should have access to affordable and reliable contraception (Norris et al., 2010). Simply consenting to sex, whilst having taken contraception does not in itself imply consent to pregnancy (Norris et al., 2010). Pro-choice advocates also claim that forcing women to continue with an unwanted pregnancy is morally wrong and that when women desire or need a termination, then the rights of the mother should override the rights of the fetus (Kumar, Hessini & Mitchell, 2009). Most participants in this research, (with the exception of Jenny), aligned themselves with themes advocated by the pro-choice movement and faced with the decision of a pregnancy termination, they cited unfavourable social and financial circumstances or mentioned that they did not want children as the reason for termination.

Perceptions of the pregnancy.

Three of the participants viewed the fetus in scientific rather than abstract or spiritual terms, and sometimes referred to the fetus as being “a cluster of cells” or “scientifically cells are alive and that explains the heartbeat”. Reducing the fetus simply to a scientific entity might have assisted participants with their post-termination adjustment, despite the fact that some experienced conflict or indifference in their relationship following the termination. The perception of the fetus in scientific terms might also explain the relatively minimal impact of the pregnancy and subsequent termination on future relationships (Coleman, Rue & Spence, 2006). Arguably, viewing the fetus in such a light, might have led to a greater acceptance and satisfaction with the medicalisation of their termination experiences. Specifically, two of these three participants reported that they were satisfied with both the level and type of care - medical versus interpersonal - that they had received. However, when there were differing perceptions and emotional connections to the fetus, relational difficulties and conflicts could arise (Coleman, Rue & Spence, 2006).

Exposure to terminations.

One half of the participants had exposure to terminations by knowing an acquaintance, friend, or family member who had experienced this. Having prior knowledge of the termination process helped participants to be more aware of the general steps, overall experience, and procedure to be followed (East, 1999). In

one participant's case, her relative's previous experience of a termination allowed her to timely and successfully guide her through the system, resulting in less stress and fewer obstacles for the participant. In other cases, close family members had a termination that gave them an insiders' view of what to expect and say to health professionals. Participants in this situation appeared to experience a higher level of quality of care and a faster referral into the termination system. Research has suggested that indirect and normative influences can affect how young women negotiate decision-making around pregnancy (Brazzell & Acock, 1988). This suggests that early conditioning, exposure, and acceptability of terminations might help women to view termination as a positive option when faced with an unwanted pregnancy (East, 1999).

This chapter has examined the bi-directional effect of intimate relationships and pregnancy terminations. It also has systematically examined the participants' experiences of the quality of care they received in the New Zealand pregnancy termination system. This chapter has also considered possible mediating factors that might influence either intimate relationships or the quality of care experienced. Finally, this chapter has presented significant themes that featured in the lived experiences of the six participants in this study, the aim of which has been to provide much richer information about a very under-researched area of inquiry in New Zealand to date.

Chapter Seven: Discussion

This qualitative thesis has examined the experiences of six young New Zealand women who have had a pregnancy termination, specifically with reference to intimate relationships and the quality of care they received. Whilst prior research has tended to focus on the relationship between termination and mental health, very little attention has been paid to two significant components that may influence the termination experience. Pregnancy terminations rarely occur in a vacuum, as often there are intimate partners, friends, family, and various interactions with health professionals that are all features of this personal journey. Taking account of this context provides much needed and valuable insight into how an intimate relationship might affect the decision to have a termination, as well as the impact of the termination on the quality and longevity of the relationship. Moreover, examining the quality of care that the six participants experienced in the termination setting provides a more detailed and richer understanding as to how this positive or negative experience might affect their overall experience of the pregnancy termination. While this research was never intended to provide definitive answers about the experiences of all women who had terminations, it nevertheless has highlighted various ways in which pregnancy terminations can be better understood.

This chapter, Chapter Seven, examines and reaffirms the significance of the analysis (Chapter 6) and findings described in earlier chapters (Chapters 4 and 5). It therefore analyses the results within a broader context, whilst also taking into consideration the limitations of this research study. This final chapter will also make recommendations for future research in this area, which is urgently needed owing to the paucity of both national and international literature regarding pregnancy terminations. Personal reflections have also been included not only to provide insight in to the researcher's journey as well as the journey of the participants but also as a means of bridging the academic and 'real life' divide.

What this thesis has established

This thesis has investigated the link between pregnancy terminations and current intimate relationships. This has been achieved by describing the chronology of a personal relationship wherein participants felt ‘robbed’ of the ‘honeymoon’ phase which then led to a sense of nostalgia, longing and loss. Because these relationships matured prematurely, the level of communication in some of these novel relationships was not sufficiently well developed to allow open and honest discussions. This sometimes led to a serious breakdown in communication and an increased desire to maintain a sense of ‘fun and spontaneity’, either pre- or post-termination. Although most of the intimate relationships dissolved after termination, this was mainly attributed to the presence of an already dissatisfying relationship that the termination experience merely exacerbated.

The pregnancy termination was associated with negative outcomes for intimate relationships when there was incongruence within the relationship post-termination and, to a lesser extent, in the period leading up to the termination. In some of the participants’ narratives there was a sense that sharing this experience with their intimate partner would lead to similar experiences, reflections, and outcomes. Difficulties were then encountered when trying to respect differences in coping at the same time as the participants were trying to move forward in their lives and sometimes, their relationships.

Pregnancy terminations also have the potential to exacerbate or to hasten relationship issues. This thesis does not support prevailing theories suggesting that terminations lead to a greater likelihood of relationship dissolution than for couples not having unwanted pregnancy. In some instances a pregnancy termination can prolong an already existing undesirable relationship.

Relationship circumstances and partner-related characteristics have been shown to be two contributors in the decision to terminate. The findings of this thesis support other research explanations for seeking pregnancy terminations: the relationship was not stable or long-lasting, or marriage was seen as a pre-requisite to becoming pregnant; the participants were in dissolved, new or unstable relationship; this was

seen as being unappealing or the “wrong guy” to have a child with, the partner cannot or will not support the participant and child; and the pregnant partner not wanting to be a single mother. However, this thesis contradicts the existing research literature that argues women who have received a termination typically do not consult with or choose to inform their intimate partner (Tatum, Rueda, Bain, Clyde & Carino, 2012). The participants in this thesis who were in an intimate relationship typically took active and persistent measures to consult with and consider their partners views on termination.

Pregnancy terminations appeared to have a moderate effect on the quality of future relationships except where women chose, or will choose to, conceal a termination from future partners. This was particularly apparent for young women who knew that their partners were opposed to terminations.

In terms of quality of care, the participants reported that the termination service was very ‘medicalised’ and they felt they were simply being processed through a “revolving door”. This affected their overall experience of the termination in ways that were markedly at odds with their initial expectations, preferences, and needs. Whilst participants appreciated an element of clinical care, especially those with science backgrounds, or who were not at all troubled by their decision, there nevertheless was a desire for more individualised and interpersonal care to be made available to them.

While some participants found the termination experience to be troubling or conflicting with their partner’s views on termination, others were aware of the authority of doctors and the need to ‘work’ the system. This involved concealing emotions when in front of the doctor and appearing to be calm and unfazed which, in some instances, contributed to increased stress on the day of termination. Participants also were required to provide an appropriate (but inaccurate) reason for their termination, which the majority of participants felt was unfortunate but acknowledged that this was a necessary legal step in order to receive a termination.

This thesis also establishes that young women who presented for termination often had difficulty accessing an initial appointment and, being in the queue to receive a termination. Delays in ‘getting a foot in the door’ often occurred because some health professionals were unwilling to refer young women for a termination which meant that participants had to visit multiple providers in order to be referred for a termination. Those participants who had formed a relationship with their local doctors typically experienced faster referral times than those who visited an unknown health professional in after-hours facilities.

Multiple accessibility barriers were identified across the participants’ narratives in terms of having to cover fuel and accommodation costs. In some cases this led to delays in accessing the termination. The majority of participants had to travel some distance (taking between 15 minutes and 3 hours and 10 minutes) to receive a termination, which meant they had to plan ahead. Delays between the time of initial consultation and the termination procedure has been shown in the literature to increase the risk of complications, both psychological and physical, and this highlights the importance of obtaining terminations as early as possible (Silva, Ashton, & McNeill, 2011).

Some young women who underwent a pregnancy termination experienced a longing for tangibility. This is a grieving mechanism that helps to validate that the experience has occurred. In the context of societal disapproval of terminations, women are at risk of experiencing ‘disenfranchised grief’. Following the termination some participants had a sense of regret concerning taking the pregnancy remains. For others, taking the remains was very important, emotionally and/or culturally, because they now had something tangible and felt a sense of closure and peace.

Ultimately, this thesis sheds light on a very complex, emotional, and individual experience shared by a group of young New Zealand women. It provides affirmation of the association between pregnancy terminations, the ‘quality of care’ expected and received, and the changing patterns of intimate relationships. It therefore is suggested that future researchers who investigate terminations should

consider these aspects in order to provide a more holistic, personal, and accurate understanding of pregnancy terminations in New Zealand

Implications of this research

The findings of this research can be used to introduce those women who are contemplating a pregnancy termination to ‘real life’ narratives of women who have undergone a pregnancy termination. The thesis therefore can be used as an open resource, to provide an opportunity to ‘hear’ other people’s circumstances, and to help normalise a ‘secret’ event. It simultaneously provides women with the chance to engage in self-reflection and an opportunity to be informed about all possibilities. Furthermore, by having narratives of pregnancy terminations, health professionals might become more aware of how best to provide culturally appropriate and patient-centered care.

The implications of this research are extensive and, for this reason, a series of suggestions have been made both for those women considering a termination and termination service providers:

Visiting a local family planning clinic on discovery of pregnancy.

Whilst some participants had positive experiences with their local family doctor or previously unknown doctor, others faced accessibility barriers when they did not receive a referral for termination. As noted throughout some of the participants’ narratives, having a local and familiar doctor can ease and hasten the time for referral to another provider. This is due to the relationship already formed between the woman and her doctor. In those instances when a woman does not have access to a familiar doctor then it might prove to be more time efficient and ‘safe’ to consult with a doctor from Family Planning. Family Planning has a reputation in New Zealand as a reproductive and sexual health service that offers clinical services in addition to education and training. It therefore might be reasonable to infer that doctors working within this specified context might be more ‘liberal’ in their outlook and better ‘informed’ concerning access (and barriers) to pregnancy termination. Family Planning also offer free services for

women less than 22 years of age (who are New Zealand residents or citizens), serving to remove a financial barrier to obtaining an initial appointment. If there are concerns regarding confidentiality and their doctor being able to view women's medical files then Family Planning has an option that can ensure confidentiality of health records within Family Planning (Family Planning, 2016). As a number of participants in this study observed, 'getting a foot in the door' for them presented a significant accessibility dilemma.

Homogenised care to individualised, social, and cultural contextualised care.

For some young women in this research, the provision of homogenised care was an appropriate expectation in the delivery of termination services. However, others disliked what they regarded as a very non-individualised and medicalised interaction with, and progression through, the termination system. Some participants, including Māori participants, experienced the feeling of being a 'number' in the queue. Upon entering the termination service, Māori women were channelled through the only service available - mainstream hospital-based care. Improved efforts could be made concerning the choice of termination providers and allowing the burial of the pregnancy remains in line with Māori cultural protocols. The increased availability of *whakatauki* (Māori proverbs), links with local *kaumātua* (elders), and Māori-based support groups might be particular measures to be trialed, or at least offered, when deemed relevant. Reviewing policies regarding whether women having terminations are allowed a partner or other support person in theatre also need to be considered. The implication of this finding is that all women considering termination should be made aware of the trend towards the provision of medicalised and homogenised care, ensuring that the gap between their expectations and the reality are minimised. Empowering women with this knowledge would assist them in making an informed decision and increase the likelihood of a more positive and less stressful experience.

Unexpected emotions may occur on the day for an intimate partner; seeking a meaningful support person.

For three quarters of the participants who had their termination partner present on the day of termination, their partner was unable to provide meaningful support,

and in fact they required additional support themselves. This occurred for participants who were in novel relationships and those who had known their partner for some time (either in the relationship or as a friend prior to their relationship formation). As the narratives in this thesis have highlighted, it is imperative that women considering a termination discuss with their partner in detail what they expect to gain from being present at the termination clinic and also to undertake prior research and ensure (confirmed in writing) that women are able to have their partners present in the operating theatre if both feel that this would be beneficial to them.

Recommendations for research in this area

The conclusions drawn from this thesis invariably open up further research avenues and possibilities in this under-researched field. Although this research sought and encouraged the participation of women of all ethnicities, the majority of participants in this thesis were New Zealand European. This pattern is consistent with New Zealand statistics (Abortion Services, 2013). Undeniably, while each and every young New Zealand women's experiences with pregnancy terminations are valid and necessary, having a greater range of cultural histories and cultural narratives might also assist individuals who identify with particular cultures or ethnicities, and allow for a more detailed analysis of the effects of culture on the overall experience of termination.

Further research could include an opportunity for participants to download a template and to fill in their narratives online. Participants therefore would have more flexibility as to when they can participate in research (for example, not having to be present physically for an interview) and have greater anonymity. Fortunately for the researcher in this thesis, having relatively recently shifted to the Waikato region minimised the likelihood of coming into contact with individuals of whom were known in other capacities. An online format might also be more efficient in obtaining a more populated sample size, which, in turn, might produce new insights as to specific conditions that tend to lead towards favourable or unfavourable termination experiences.

Other research suggestions include further exploration of the finding that pregnancy terminations had little impact upon future relationships. This is important as this finding is markedly at odds with the international research literature.

Research limitations

The in-depth, multiple case study, and semi-structured nature of this research elicited open discussions regarding a very personal and seldom disclosed experience. Whilst the nature of these successive and in-depth narratives allowed flexibility regarding where the interview could lead both interviewer and participant, there are some limitations in adopting this approach.

The sample size in this study was reasonably small. Whilst these narratives were revealing, the results obtained from them cannot (and should not) be extrapolated to all young women who have had a pregnancy termination. What this thesis does reveal, however, is that in the context of complex particular outcomes and experiences, valuable individual insights can be obtained. The researcher therefore intentionally made the choice to proceed with a small sample of six participants in order to elicit and understand the rich, individual, and highly personal information about a very under-researched area.

A further limitation arises from the very nature of narrative analysis wherein the researcher intentionally selects what he or she deems as significant within the narrative. Whilst strategies were employed to mediate this effect – participants were provided with a written version of their narrative and encouraged to correct these - in the form of ‘deleting’ ‘elaborating’ or ‘down-playing’ – the dynamics of researcher involvement cannot be ignored. This was acknowledged through the use of multiple interviews that allowed participants numerous opportunities to engage with and take ownership of their own story by clarifying meaning either through email communications or in the face-to-face interviews. The researcher also engaged in repeated listening of the audio-recordings, and was able to clarify any misunderstandings or uncertainties with the participants. The lengthened process of analysis owing to the length of time between interviews, provided a

further opportunity for insights and reflections, and to undertake any corrections to the interview transcripts identified by the participants.

No provision was made to include only those participants who were in an intimate relationship at the time of the pregnancy termination. Two of the six participants in this research had initiated cessation of their relationship either prior to the discovery of their pregnancy or prior to the termination. The latter example included a relationship break-up one week after the pregnancy was discovered, with no further interaction with the partner owing to a court hearing and the partner's associated abusive tendencies. Had participants been recruited who met the original criteria then more insight into the possible bi-directional relationship of intimate relationship and pregnancy termination might have been forthcoming. In this regard, while participants were able to comment on how an intimate relationship (aversive or the absence of one) may have affected the decision to terminate, they were not able to comment on how the termination had a bearing on their relationship. Because this was only discovered later in the research process, the decision therefore was made to interview a slightly larger sample size than initially intended, as a means of partially compensating for this. Findings from the effect of the termination on the relationship therefore tended to focus on the extent to which distance was created between the woman and her partner.

A further, albeit relatively minor, limitation that emerged during the course of interviewing one participant was her ability to recall the details of one termination that had happened many years earlier. In this case the participant had difficulty recalling her interaction with her sonographer. This meant that particular areas relating to the quality of care she experienced had to be omitted from her narrative.

Personal reflections

At the outset of this research I was ambivalent about investigating this topic because I was aware of the criticism that had been directed at Professor Fergusson who had completed a longitudinal study into the relationship between mental

health outcomes and pregnancy terminations (Fergusson, Horwood, & Ridder, 2006). Accordingly I also am aware of the potential for this research thesis to attract similar criticism and for particular groups with specific agendas to use this research as ‘ammunition’ to support their respective causes. Somewhat optimistically it is hoped that this research instead is used to provide academic validation and substance to an issue that largely has been ignored in New Zealand. It is the researcher’s understanding that if the status quo is not subjected to critical examination, then this detracts from the ultimate goal of ensuring societal wellbeing through healthy and respectful engagement in difficult and critical conversations. The researcher encourages others pursuing similar fields to strive for answers to controversial questions and not to be afraid of researching those areas identified as being ‘unworthy’ or ‘not useful’.

When initially interviewing participants many spoke about the stigma they faced when seeking to terminate their pregnancy. At the outset, this represented a challenge for myself as a reasonably novice researcher. On the one hand I was trying to adhere to the narrative philosophy of allowing participants to tell their story in a way that makes sense for them and at the same time, needing to address the research questions that I had set. Whilst I was seeking to gain a holistic understanding of the experience for participants I was particularly interested in participants’ intimate relationships and the quality of care they received in relation to the pregnancy termination. Initially I struggled to see the relationship between stigma and how this was related to the participants’ experiences of quality of care or their current and future relationships. However, as the semi-structured interviews progressed, the notion of stigma became fundamental to participants’ experiences of their termination. In particular, this stigma sometimes led to a new relationship having to carry the load of a past stressful experience or maintaining secrecy about the termination when in future relationships. In terms of quality of care, stigma had a central role in how participants experienced the progression through the termination system. In some narratives, stigma effected their expectations of their care, their interactions with health care professional, as well as their hesitation in confiding to individuals following the termination. The decision to allow participants some degree of flexibility in the narration of their

experience helped to facilitate unexpected and additional insights that strengthened the essence and significance of the narratives.

It was a genuine pleasure to interview all six participants, each of whom offered different, but revealing, narratives that contributed towards knowledge of pregnancy terminations in New Zealand. The level of engagement of participants in this research was such that each was able to demonstrate considerable insight into their own narratives in addition to acknowledging the prevailing New Zealand social climate concerning the legitimacy (or otherwise) of legalised pregnancy terminations in New Zealand. Having such dedicated, thoughtful, and reflective participants made the process of interviewing something that the researcher genuinely looked forward to. The collective narrative that the participants wove helped to dispel myths surrounding pregnancy terminations as being a 'doom and gloom' event because they were able to live fulfilling lives, utilise their resiliencies, and to learn valuable life lessons along the way. Working alongside these participants has further cemented my passion for youth wellbeing, and confirmed my decision to make this a specialty area in my career.

The researcher envisages that the findings of this thesis will initiate considerable and ongoing discussion, and add valuable insight about young women's experiences concerning pregnancy terminations. This thesis provided the opportunity for six young New Zealand women to engage in self-awareness, reflection, and general discussion with a fellow human being about a very private and personal decision and experience. It also contributed towards an increasing knowledge base that is largely untapped in New Zealand, requiring the researcher to draw upon international research. Because New Zealand is a unique country with associated socio-political and historical influences and circumstances, it is crucial that further research is undertaken to help fill this void and to increase the knowledge base about the very individual (and often lonely) experience of pregnancy terminations. This thesis provides a basis upon which future research can follow. It is hoped that researchers will take this opportunity to delve further into this topic and, in the process, assist in the construction of a collective and more sophisticated narrative for a group of women who, to date, have largely been marginalise

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Appendix A

The number of young women presenting for termination who have had previous terminations (Abortion Services, 2013).

Year	None	One previous termination	Two or more previous terminations
1991	8913	2163	537
1992	8716	2249	630
1993	8813	2340	740
1994	9400	2613	822
1995	9806	2892	954
1996	10576	3162	1067
1997	10667	3356	1185
1998	10302	3504	1223
1999	10442	3710	1349
2000	10710	3851	1542
2001	10830	3961	1619
2002	11458	4164	1758
2003	12169	4473	1869
2004	11696	4490	2025
2005	11210	4345	1876
2006	11548	4360	2026
2007	11884	4380	2118
2008	11312	4469	2159
2009	11014	4423	2023
2010	10223	4427	1980
2011	9821	3974	2068
2012	9160	3648	1937

Appendix B

The number of previous life births for women who have presented for termination (Abortion Services, 2013).

Year	None	One previous child	Two or more previous children
1991	5810	2091	3712
1992	5616	2152	3827
1993	5733	2162	3998
1994	6186	2312	4337
1995	6507	2555	4590
1996	7130	2777	4898
1997	7189	2777	5071
1998	6977	3082	4970
1999	7141	3090	5270
2000	7547	3133	5423
2001	7682	3148	5580
2002	8457	3233	5610
2003	9451	3312	5748
2004	9216	3366	5629
2005	8894	3245	5392
2006	9078	3401	5455
2007	9197	3582	5603
2008	8721	3596	5623
2009	8370	3580	5600
2010	7785	3419	5426
2011	7147	3352	5364
2012	6504	3139	5102

Appendix C

Number of women presenting for termination by ethnicity (Abortion Services, 2013).

	European	Māori	Pacific	Asian	MELAA	Other	Not stated	Total
2002	9763	3899	2009	2860	152	0	0	17380
2003	10271	4053	2161	3502	193	0	3	18511
2004	10358	3906	2060	3175	214	0	7	18211
2005	9732	3882	2050	2957	220	0	149	17531
2006	9859	4097	2134	2935	203	51	211	17934
2007	10546	4304	2289	2947	206	48	246	18382
2008	10499	4250	2230	2875	216	25	64	17940
2009	10113	4131	2360	2892	207	23	57	17550
2010	9378	4056	2228	2778	189	17	126	16630
2011	9044	3855	2054	2649	169	22	25	15863
2012	8266	3596	1985	2480	158	12	50	14475

MELAA = Middle Eastern, Latin American or African ethnicity

Appendix D

*School of Psychology
Waikato University*



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Young New Zealand women and pregnancy terminations: intimate relationships and service experiences

Firstly, thank you for considering to participate in this valuable research on understanding women's experiences of pregnancy terminations.

Overview

My name is Katherine, and as part of the Master of Arts programme, I am required to conduct and report on a research project in the form of a thesis. For my thesis I wish to research the experiences of young women who have had a pregnancy termination, in a New Zealand context. I am specifically focusing on women's health care service experiences as well as intimate relationships related to a termination: how relationships affected decision-making and coping post-termination and how the experience of a pregnancy termination affected present and future intimate relationships. The only requirements of the study are that you were aged 25 years or younger at the time of your termination and had the pregnancy confirmed (e.g., this excludes the morning after pill).

Initially my interest in this topic grew from my work in the youth and social services. When I encountered a youth who had an unwanted pregnancy and desired a termination, I was required to refer the youth. I soon discovered that this was an under researched area in New Zealand. This thesis is an extension of my honours dissertation from last year, which was broad and focused on the totality of the experience. However, my thesis has a specific focus on health care service experiences and relationships in relation to a pregnancy termination.

This study aims to explore how a pregnancy termination affects present/future intimate relationships and how the relationship affects the overall experience of a termination: decision-making, post-termination coping and life after termination. The study also aims to explore women's experiences of the quality of care they received in relation to their termination. Quality of care will cover interpersonal aspects of health professional staff you encountered, clinical aspects such as successful procedure, informed choice, etc as well as accessibility: both geographically and financially.

A narrative approach will be used throughout the interview and analysis process. This means that I am interested in your stories and how you tell these stories. These stories are believed to shape your life and are adopted from ideas, beliefs, social structures and norms that govern everyday life. Through a narrative approach we will uncover your story, where you have an active role in clarifying your story. You will therefore be encouraged to correct, change or delete parts of your interview summary that I write up following each interview. It is in this sense that we co-construct your story.

What is all this paperwork?

All participants will receive an information pack that explains what this research entails. You will receive a participant information sheet (what you are reading now), a consent form, a demographic questionnaire as well as a form outlining themes to be covered during the interview. These themes are a rough guide and will not be answered in question and answer format, rather, you will be invited to share your story openly and I will direct you to the necessary themes if needed.

The consent form requires you to tick the boxes that you consent to. We will both then have to sign and date the bottom of the page if you are willing to participate in this research. The demographic questionnaire allows myself as the researcher to connect with your unique experience as well as tailoring the

interview questions if needed. As for the themes form: this allows you to be fully aware of the content of the interview – hence no surprises!

What will you have to do and how long will it take?

Participants will be interviewed for approximately 1 hour on 3 separate occasions, 1:1 with the researcher. This may be shorter and depends on the depth and breadth of information obtained. Following each interview, I will send each participant their interview summary to amend and one week will be allocated for this to happen. If one-week lapses and the participant has not replied, I will take my account of the interview summary to be accurate of your story.

The location of the interview will need to be in a relatively quiet environment but can be negotiated between the researcher and participant. Tea/coffee and biscuits will be provided. This is a chance for participants to share their experience regarding pregnancy termination in a professional, non-judgmental and confidential environment. All participants will be provided with a list of counselling services in the respective region, which may or may not be utilised by the participant.

Participants may also bring a support person/*whānau* to the interviews if they wish.

For the purpose of this research project I wish to record the interviews if possible. This is so I can ensure that your story is accurately captured. However, you may choose not to consent to this (as indicated on the consent form) and are still able to participate in this research.

Themes that will be discussed include:

- Life before falling pregnant: ambitions/goals, relationships with family and friends
- Intimate relationships – past, present and future

- How you felt when you first found out that you were pregnant
- Factors that contributed towards your decision
- Culture and ethnicity
- Religion, and family of origin
- The quality of care you received: interpersonal aspects – sensitivity, honesty, empathy, tact, informed choice and technical aspects – complications, comfortability, privacy, convenience, quiet etc.
- Life after falling pregnant
- Putting it all together – knowledge and advice

What will happen to the information collected?

Your responses will be incorporated into my Masters thesis about young New Zealand women's experiences of a pregnancy termination. Only I will have access to personal information and personal details whereas my supervisors will have access to the formalised interview summary following the interview.

Participants will be anonymised unless explicit consent has been given to the contrary.

Rights

If you take part in the study, you have the right to:

- Refuse to answer any particular question, and to withdraw from the study
- Ask any further questions about the study that occurs to you during your participation or after the interview
- Request a copy of my completed thesis
- Refuse your interview to be audio recorded and still participate in the research
- Edit the summary after each interview

Contacts

My supervisor Professor Linda Waimarie Nikora can be contacted through psyc2046@waikato.ac.nz and extension 8200.

My second supervisor Dr Neville Robertson's contact details are scorpio@waikato.ac.nz and extension 8298.

Otherwise, if you have any concerns about the ethics of this research you can contact the Convenor of the Psychology Research and Ethics Committee (Dr James McEwan, Tel: 07 838 4466 ext 8295, email: jmcewan@waikato.ac.nz).

Last words

Please do not hesitate to email me if you have any further questions (katherine.lee3623@gmail.com). I will endeavour to respond within 2-3 working days.

Thanks again for considering to participate in this research. I look forward to hearing from you soon 😊

Appendix E

Counselling services in the Waikato region

- 0800 773 462 – 24/7 confidential phone line specifically for post-abortion counseling.
- Student counselling service at Waikato University: Phone 07 838 4037 or email student_services@waikato.ac.nz. This is a free service for University students.
- Karen McCurry: Registered counselor with particular experience with grief and loss. Phone 027 552 4519
- Donna Cooney: Registered counselor also with experience in grief and loss. Phone 07 859 2929 or email admin@counsellingworx.co.nz
- Relationships Aotearoa: Not just a service for relationships but for individual sessions on grief and loss. Phone 07 839 3267 or email Hamilton@relationships.org.nz
- Rape and sexual abuse healing centre. Phone: 07 839 4433 or email rasahc@xtra.co.nz. Drop in at 33A Clarence Street, Hamilton.
- Lyn Burgess. Phone: 07 839 6850 or email: lburgesscounselling@xtra.co.nz. Address: Suite 2, Reid House, 114 Alexandra street, Hamilton.

Counselling services in the Manawatu region

- 0800 773 462 – 24/7 confidential phone line specifically for post-abortion counseling.
- Student counseling service at Massey University. Phone 06 3505533 or extension 85533. Alternatively you can email s.counselling@massey.ac.nz
- Pregnancy counseling service at Palmerston North Hospital (Social work unit). Phone (06) 3508322 for counseling services post termination
- Women's Health Collective. Phone (06) 357 0314
- Youth One Stop Shop. Free counseling for youth aged 9-25. Phone (06) 355 5906. Alternatively visit the website www.yoss.org.nz
- Ministry of Health Depression Helpline 0800 111 757. Help available from 8pm until midnight 7 days a week.