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**LA THÈSE A ÉTÉ
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PSYCHOLOGICAL CHARACTERISTICS OF ANGLOPHONE AND FRANCOPHONE
INITIAL AND REPEAT ABORTERS AND CONTRACEPTORS

Charlene Berger

A Thesis
in
The Department
of
Psychology

Presented in Partial Fulfillment of the Requirements
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Concordia University
Montréal, Québec, Canada

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ABSTRACT

PSYCHOLOGICAL CHARACTERISTICS OF ANGLOPHONE AND FRANCOPHONE INITIAL AND REPEAT ABORTERS AND CONTRACEPTORS

Charlene Berger, Ph.D.
Concordia University, 1978

The main purpose of this study was to further an understanding of the psychological characteristics of women who have first and repeat abortions, and to differentiate between initial and repeat aborters and contraceptors on a number of selected variables. This was attempted, in part, by extending Byrne's conceptualization of a continuum of attitudes towards sex-related topics to the study of abortion patients, which suggests that abortion patients would have more conservative attitudes towards sex roles, sexuality, contraception, and abortion than never-aborted contraceptors, and that repeat abortion patients would have more conservative attitudes than first aborters. It was predicted that abortion patients would have a more external locus of control than contraceptors, with repeaters being more external than initials. It was posited that contraceptors would know more about contraceptive devices and techniques than abortion patients, with initials knowing more than repeaters. It was predicted that initial aborters would acquire more birth control knowledge than repeaters from contraceptive counselling. It was posited that while within the normal range of functioning abortion patients would have poorer personality adjustment scores than contraceptive patients, with repeaters demonstrating the most elevation. It was predicted that

contraceptors would have been in their relationship with their sexual partners for a longer duration than abortion patients, with repeaters reporting the shortest duration. Finally, it was predicted that abortion patients would report less satisfactory involvements than contraceptors, with repeaters reporting the poorest quality relationships. The abortion group consisted of 448 Anglophone and Francophone women scheduled for a first trimester pregnancy termination. Overall, 52 percent of the women seeking an abortion reported not having used any form of birth control in the month they conceived. Slightly more than 21 percent of the abortion group had had a previous abortion. The contraceptive group consisted of 109 never-aborted women who were using intrauterine devices. The main technique of data analysis was multivariate analysis followed by univariate analyses. The design of the study was a 3 X 2 factorial for the variables Group (repeat aborter, initial aborter, contraceptive) by Language (Anglophone, Francophone). The usefulness of the Byrne conceptualization understanding abortion behavior was largely supported. Women who are seeking abortions are more erotophobic than the contraceptors. They have more conservative attitudes towards sex roles, sexuality, and contraception, and know less about contraception. Contrary to prediction, repeat abortion patients hold more favourable attitudes towards abortion than contraceptors and initials. This finding was discussed in terms of Festinger's cognitive dissonance theory. There were no significant differences between the linguistic groups on any of the attitude scales. The groups did not differ on locus of control. The prediction that abor-

tion patients know less about contraception than the contraceptors was largely supported. Repeaters and initials did not differ on the amount of information gained from contraceptive counselling. The initial aborters and, to a lesser extent, the repeaters, demonstrated poorer physical and cognitive functioning than the contraceptors. However, their scores were within the normal range. The groups did not differ on the scales which assess affective functioning. The groups did not differ from each other on length of relationship; however, it was found that repeaters reported being involved in poorer relationships than initial aborters. Overall, the two abortion groups were essentially similar. It was suggested that both abortion groups consist of a heterogeneous sample of patients and that certain basic dimensions differentiate in a similar fashion within each of these groups. A post hoc analysis showed that non-contraceptors within both the repeat and initial abortion groups hold less favourable attitudes towards sex roles, sexuality, contraception, and abortion. The results of this study and other research were used as a basis for recommendations for the counselling of subgroups of abortion patients.

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Introduction

Abortion recidivism is an issue that is drawing an increasing amount of attention from health and welfare personnel in both North America and abroad (Aitken-Swan, 1973; David, 1973; Osborn, Note 1; Pakter, Nelson, & Svirar, 1975; Rovinsky, 1971, 1972; Schneider & Thompson, 1976; Tietze, Note 2). The number of legal initial and repeat abortions performed annually in North America has increased over the last decade (Badgley, Note 3; Oskamp, Mindick, Hayden, & Pion, Note 4). This increase has occurred despite the fact that there has been an increase in the use of contraception and an increased reliance on the more effective contraceptive techniques since the 1960's (Westoff, 1976a; 1976b; Westoff & Jones, 1977; Zelnick & Kantner, 1977).

In the United States in 1976 the number of legal abortions performed nearly doubled the 1972 rate totalling 1,070,400 abortions (Lincoln, Döring-Bradley, Lindheim, & Cotterill, 1977; Weinstock, Tietze, Jaffe, & Dryfoos, 1975). Greater increases in the rates of therapeutic abortions being performed in Canada have also been reported with several writers expressing concern at this trend (Ball, 1972; Gentles, Kremer, Landolt, & Morris, 1974; Hannah, 1972). When all categories of abortion are considered, legal, illegal, and those performed on Canadian residents outside Canada, one out of every six pregnancies is currently

terminated by abortion (Badgley, Note.3). The 1975 rate is over four times that of 1972, totalling 49,500. Preliminary data suggest that there was a 10 percent increase, over the 1975 figure, in the number of therapeutic abortions performed in Canada in 1976 (Wadhera, 1977).

These increases in abortion rates are undoubtedly related to the liberalization of the abortion laws in 1969 and 1970 in Canada and the United States, which no longer confined legal abortions to circumstances that threatened the life of the mother. Therapeutic abortion in Canada was allowed if continuation of the pregnancy was seen to pose a threat to the life or health of the mother. Prior to the liberalization of abortion legislation in North America, a great many women were obtaining illegal abortions. Estimates of the number of illegal abortions being performed annually before 1970 ranged from 30,000 to 300,000 in Canada (Report of the Royal Commission on the Status of Women, 1970) and 200,000 to 1,500,000 in the United States (Chisolm, 1971; Lader, 1966, Pipel & Norwick, 1969). It is most probable that many women who would have previously procured abortions under illegal circumstances have since been seeking legal pregnancy termination (Steinhoff, Diamond, Palmore, & Smith, Note 5). According to the Report of the Committee on the Operation of the Abortion Law (Badgley, Caron, & Powell, 1977) only 1,441 abortions were performed extralegally in Canada in 1974, compared to 48,136 legal abortions. As more North American women seek to terminate unwanted pregnancies legally rather than illegally, the number of legal abortions is bound to increase.

Another factor that serves as a basis for expecting an increase in

the rate of abortions is that more young people in North America are engaging in premarital sexual intercourse and are doing so at an earlier age than their predecessors (Zelnick & Kantner, 1977). Although there has been an increase in the prevalence of contraceptive use among unmarried sexually active teenagers, there has also been a simultaneous increase in the proportion of sexually active young women who have never used contraception (Zelnick & Kantner, 1977). Consequently, there are many unmarried teenagers open to the risk of unplanned pregnancy.

Examination of the characteristics of women seeking abortion reveals that teenage girls have an abortion rate disproportionate to their percentage of the population of women of childbearing age (Zelnick & Kantner, 1978). It appears that for many teenagers abortion has increasingly become the solution to undesired and out-of-wedlock pregnancy. Between 1972 and 1975 the number of abortions performed on teenagers more than doubled, so that at the present time approximately one third of all abortions are performed on teenagers (Alan Guttmacher Institute, 1976).

Another large group of women who are expected to continue to have abortions are those interested in limiting their family size, since the desired family size has been declining (Westoff, 1976a). It appears that many married women who might previously have carried unwanted pregnancies to term are now choosing to have abortions. Reports indicate that women in the United States who request abortions are primarily women at the two ends of the fertility age range, that is women who are married, already have children, and wish to limit their family size,

and those women who are young, single, and childless (Steinhoff, 1973). Similarly, according to the Report on the Operation of the Abortion Law (Badgley et al., 1977), 68 percent of the women who obtained legal pregnancy terminations were single, separated, or divorced, while 31 percent were married.

Repeat Abortions

Several writers have expressed concern over the rising number of repeat abortions being performed in North America (Aitken-Swan, 1973; David, 1973; Osborn, Note 1; Rovinsky, 1971, 1972). Reports of the prevalence of repeated abortion seeking as a proportion of all abortions, have ranged from four to 22 percent (Addelson, 1973; Bogen, 1974; Bracken, Hachamovitch, & Grossman, 1972; Bracken & Kasl, 1975b; Cobliner, 1974; Freeman, 1978; Hall, 1971; Luker, 1975; Margolis, Davison, Hanson, Loos, & Mikkelsen, 1971; Margolis, Rindfuss, Coghlan, & Rochat, 1974; Monsour & Stewart, 1973; Oskamp, Mindick, Hayden, & Pion, Note 4; Pakter, Nelson, & Svigar, 1975; Tietze & Lewit, 1972).

The proportion of women having had two or more abortions has been rising steadily since the late 1960's (Claman, Wakeford, Turner, & Hayden, 1971) and now ranges from 18 to 22 percent in both Canada and the United States (Center for Disease Control, 1977; Osborn, Note 1; Oskamp et al., Note 4; Pakter et al., 1975). According to Badgley et al., (1977), "the proportion of women having repeat abortions may have more than doubled" across Canada from 7.9 percent in 1974 to 17.9 percent in 1976. Higher prevalence rates can be expected once the abortion code has been liber-

alized for a longer period of time; as the probability of a repeat abortion appears to increase as a function of time.

In 1974, Tietze presented a mathematical model which attempts to predict the likelihood of repeat abortion based on the published rates of effectiveness of the various contraceptive techniques (see Appendix A). The model takes into account human failure factors, lower and higher levels of fecundability, and the amount of time since abortion law liberalization. According to Tietze's formulations a significant incidence of repeat abortion, 1.8 to 5.3 percent, can be expected to occur within a year following a first abortion among women using the oral contraceptive. With other less effective contraception, 8.6 to 24 percent of the women can be expected to experience a repeat abortion within a year of their first abortion.

Previously mentioned research provides some support for Tietze's formulations. Rovinsky (1972) reported that during the first year following New York's liberalization of the abortion code five percent of the women returned for a repeat abortion. Similarly, Daily and his colleagues (1973) reported that 3.94 percent of New York residents returned for a second abortion within 12 months of liberalization of the law. These figures fall within Tietze's estimates of repeat abortion for the first year after abortion liberalization.

Tietze's model presumes that the aborter who is using contraception before the undesired pregnancy will continue to do so after her first legal pregnancy termination. The model does not take into account the percentage of women who were not using contraception during

the month they conceived and who terminate their pregnancy.

Tietze's statistical predictions should not be used as evidence to accept the inevitability of increasingly higher rates of repeat abortions. Sandberg and Jacobs (1971) have commented that even if the technology existed to create the ideal contraceptive, psychological and interpersonal factors remain that would contribute to undesired pregnancy and subsequent abortion. Thus, Tietze's predictions underscore the necessity of delineating those psychosocial factors which may be associated with and contribute to repeated undesired pregnancy and subsequent repeated abortion in an effort to arrest what appears to be an increasing rate of repeat abortions.

The Abortion Experience Abroad

While differences in cultural, legal, and social factors make international comparisons difficult, similar trends of increasing rates of the number of women seeking repeat abortions across many countries warrant consideration from North American investigators. In many foreign countries, the abortion codes have been liberal for longer periods of time than in North America (David, 1973; Osofsky & Osofsky, 1972; Tietze, Note 2). In Eastern Europe, for example, abortion was legalized in the Soviet Union in 1955, in Poland, Bulgaria, and Hungary in 1956, Czechoslovakia in 1957, and Yugoslavia in 1960 (Mehlan, 1970). Multiple abortion is apparently more accepted as a method of birth control in Japan and Eastern Europe, whereas public opinion in the West has generally been against the use of abortion as a form of birth control.

(Brewer, 1977b).

In Hungary, while abortion has been legal since the mid 1950's, surgical sterilization is prohibited. The proportion of repeat abortions, among all abortions, ranged from 58 to 60 percent during the period 1964 to 1970 (Tietze, 1974). Furthermore, the percentage of women having three or more abortions rose from 12 to 24 percent between 1960 and 1969 (Szabady, 1969; Szabady & Klinger, 1972). Similarly, Sadvokasova (1969) indicated that 15 percent of the women who had an abortion in 1958-1959 in the Soviet Union had a subsequent abortion within one year.

Generally the earlier reports from overseas had suggested that women were choosing to abort rather than to use contraception (Bracken & Kasl, 1975a; Hoffmeyer & Norgaard, 1964; Koya, 1954; Urban, 1964); however, more recent studies from Israel (Bachi, 1970), Taiwan (Chow, 1970), Hungary (Klinger, 1976, 1977; Szabady & Klinger, 1972); and Yugoslavia (Antonovski & Lazarov, 1976) appear to indicate that women who have experienced higher order abortions are also more likely to practice contraception than first aborters. In Japan, where abortion has served as a method of birth control, contraceptive use has been growing. The expectation has been that it would lead to a decrease in higher order abortion seeking (Potts, 1967); however, recent reports indicate that abortion is still a major form of birth control in Japan (Malcolm, 1978). This point of whether abortion is used as a form of birth control will be returned to later in the introduction.

It was believed that cultural and psychosocial factors and differences in the availability of modern contraceptive methods accounted for

the observed differences in abortion seeking behavior between foreign and North American populations in the early 1970's (David, 1973). However, consideration of similar trends toward increasing rates of repeat abortions in North America and foreign countries suggests that these earlier differences are diminishing rather than widening (Badgley, Note 3). The similarity in trends suggests that a further increase in higher order abortion seeking may also be expected to occur in Canada and the United States. The problem of higher order abortion seeking is of sufficient magnitude in Canada to warrant the attention of family planning researchers in general, and social psychologists in particular.

Medical and Psychological Sequelae of Abortion

Early abortion is associated with fewer health risks than pregnancy and childbirth (Cates, Grimes, Smith, & Tyler, 1977; Cates & Tietze, 1978; Tietze, 1977; Tietze, Bongaarts, & Schearer, 1976; Tietze & Lewit, 1977). Recent evidence strongly indicates that early abortion is less risky than the use of certain contraceptives by women with particular family histories, e.g., circulatory disease and/or particular behavior patterns, e.g., smoking (Beral, 1976, 1978; Beral & Kay, 1977; Vessey, McPherson, & Johnson, 1977). Nevertheless, several medical risks have been attributed to early abortion. These risks include excessive bleeding, trauma, infection, and a small but not negligible mortality rate (Beric & Kupresanin, 1971; Cates, Schultz, Tyler, & Grimes, Note 6; Jurukovski & Sukarov, 1971; Rovinsky, 1971; Stallworthy, Moolgaoker, & Walsh, 1971; Tietze & Lewit, 1972). In Canada 3.2 percent of the women

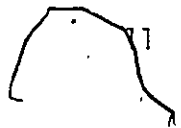
who had a therapeutic abortion in 1975 had at least one complication, for example retained products of conception, hemorrhage, cervical laceration, infection, or perforation of the uterus (Statistics Canada, 1977). In comparison with early abortion, later termination of pregnancy has been shown to be associated with higher risk of mortality and serious medical complications such as pelvic infection and hemorrhage (Berger, Tietze, Pakter, & Katz 1974; Cates, Gold, & Tyler, Note 7; Tietze & Lewit, 1971, 1972).

The relation between induced abortion and the outcome of subsequent pregnancies is uncertain. Several studies have reported such negative effects of previous induced abortion as cervical incompetence, miscarriage, stillbirth, secondary sterility, ectopic pregnancy, prematurity, low birth weight, neonatal mortality, retained placenta, and congenital malformations (Bognar & Czeizel, 1976; Harlap & Davies, 1975; Liu, Melville, & Martin, 1972; Panayotou, Kaskarelis, Miettinen, Trichopoulos, & Kalandidi, 1972; Pantelakis, Papadimitriou, & Doxiadis, 1973; Peel, 1971; Richardson & Dixon, 1976; Tietze & Dawson, 1973; Wright, Campbell, & Beazley, 1972). Roht and his colleagues have reported that multiple abortions are associated with prematurity and spontaneous abortions in subsequent pregnancies (Roht, Aoyoma, Leinen, & Callen, 1976). In contrast, the results of fewer studies have failed to demonstrate an association between previous induced abortion and the outcome of subsequent pregnancies (Daling & Emanuel, 1975, 1977; Hogue, 1974; Kline, Stein, Susser, & Warburton, 1978; Lean, Hogue, & Wood, Note 8; Roht & Aoyoma, 1973, 1974). Thus the bulk of available medical evidence suggests that

repeated induced abortion is associated with risks to the health of the woman and, in addition, may jeopardize her subsequent pregnancies.

According to the literature in North America and abroad demonstrations of serious negative psychological sequelae of abortion are rare (Athanasiou, Oppel, Michelson, Unger, & Yager, 1973; Bracken, Hachamovitch, & Grossman, 1974; Brekke, 1958; Brody, Meikle, & Gerritse, 1971; Callahan, 1970; Ekbal, 1954; Fingerer, 1975; Fleck, 1970; Gillis, 1969; Greenglass, 1976, 1977; Høkk, 1963; Jacobsson & Solheim, 1975; Kolstad, 1957; Levene & Rigney, 1970; Moore-Cavar, 1974; Osofsky, Osofsky, & Rajan, 1971; Pare & Raven, 1970; Smith, 1973; Walter, 1970). However, many authors have reported that the abortion experience may be disturbing, although not severely so (Brody et al., 1971; Greenglass, 1977; Lipper, Cvejic, Benjamin, & Kinch, 1973; Luker, 1975; Monsour & Stewart, 1973; Osborn, Note 1; Shusterman, 1976). Negative sequelae are more likely to develop when the woman is ambivalent about the decision to abort (Osofsky & Osofsky, 1972), is concerned about the consequences of the abortion (Smith, 1973), has a desire for future children (Greenglass, 1977), or is involved in an unstable relationship (Shusterman, 1976). Guilt (Osofsky & Osofsky, 1972; Smith, 1973) and mild depression (Ford, Castelnuovo-Tedesco, & Long, 1971; Jacobsson & Solheim, 1975; Peck & Marcus, 1966; Simon, Senturia, & Røthman, 1967) are the two most oft cited sequelae. Moreover, Adler (1976) has suggested that the repeater may be more upset initially about her undesired pregnancy and its implications than the first aborter.

Abortion is also a costly solution to the problem of undesired



pregnancy. . Studies in the United States and Canada have shown that abortion can be expensive for both the individual and society, especially when compared to the cost of conventional contraception (Badgley et al., 1977; Bracken, 1977; Jaffe & Cutright, 1977; Lincoln et al., 1977; Osborn, Note 1; Watt, 1974).

A Psychological Conceptualization of Sexuality in Relation to Contraception

The majority of the available research within the population and family planning disciplines has not been of a theoretical nature. In general, demographic and sociological studies have attempted to relate socioeconomic and sociocultural characteristics of women to their family planning and contraceptive behavior. Relative to other disciplines, psychology has only recently begun to investigate contraceptive and sexual behavior within a theoretical framework.

Byrne and his colleagues (Byrne, 1977a; Byrne, Fisher, Lamberth, & Mitchell, 1974; Byrne, Jazwinski, DeNinno, & Fisher, 1977; Fisher, Fisher, & Byrne, 1977), have applied the reinforcement-affect model to the study of erotica and contraception, and have proposed that individuals can be categorized along an erotophobe-erotophile continuum according to their attitude toward sexuality. According to Byrne et al. (1974), erotophobes experience negative affect when exposed to erotica and contraception-related stimuli as a result of "numerous affect-eliciting rewards and punishments that were associated with sexual matters during the socialization process" (p.145). Furthermore, Byrne has postulated that an individual's evaluation of an erotic stimulus will vary with the magnitude of the positive or negative affect con-

ditioned to it. Erotophobes, in contrast to erotophiles, possess negative attitudes toward sex, abortion, and contraception; they hesitate to discuss sexual matters, and have inadequate sexual knowledge. Byrne has suggested that while erotophobes' negative affect is not sufficient to inhibit their sexual behavior completely, it can interfere with effective contraceptive behavior.

Byrne and his colleagues have formulated a theoretical model to explain the non-use or ineffective use of contraception (Byrne et al., 1977). The model features four components of contraceptive behavior that are necessary to avoid undesired pregnancy. Individuals must first admit that intercourse is likely to occur; they must then acquire the necessary contraceptive from a pharmacy or physician; communication must occur between the partners in regard to sex and contraception; and last, the contraception must be used. According to Byrne, whether or not individuals initiate and successfully complete such a sequence of behavior is determined largely by the affective reaction that they experience at each stage of the sequence. Thus, erotophobes, who experience predominantly negative affect regarding sexual matters, are less likely to admit that intercourse may occur and prefer to experience sex as a spontaneous event. Erotophobes are also more likely to experience guilt and shame in attempting to obtain birth control methods, and evaluate contraception negatively. They avoid communicating about sex and contraception with their partner and finally are less likely to use or continue to practice contraception. Thus, the more negative, anxious, or guilty erotophobes are concerning sex, the more

likely they are to risk unwanted pregnancy. In contrast, erotophiles are more likely to attend to their contraceptive needs and prevent undesired pregnancy. Rotter (1966) has found that individuals with an internal locus of control are more actively involved in gaining information about their environment and in shaping their environment than individuals who perceive control of events as being external to themselves. Byrne (Byrne et al., 1977) has extended this to hypothesize that an individual's contraceptive behavior is also partly determined by the extent of her belief that she controls her own fate.

The result of earlier studies lend support to Byrne's model inasmuch as an association has been demonstrated between sex guilt and anxiety and ineffective use of contraception (Gerrard, 1974; Kane & Lachenbruch, 1973; Lindemann, 1974). Abortion patients have been reported to have more sex guilt than nonpregnant controls who were equally sexually active (Gerrard, 1974). Schwartz (1973) reported that subjects with high sex guilt retained less information than low sex guilt subjects after exposure to a lecture on birth control. Fisher and his associates (Fisher et al., 1977) reported a relation between purchasers' affective and evaluative responses of contraception. The more negative the subjects' affective responses were to the purchase of contraception, the more negative was their evaluation of the condoms in general, and their reliability in particular.

In summary, Byrne (1977a, 1977b) has proposed that erotophobes hold negative attitudes toward contraception, sex, and abortion, and have inadequate sexual and contraceptive knowledge, and that these fac-

tors among others interfere with the adequate acquisition and utilization of contraception, and consequently place the couple at risk for unplanned pregnancy. Byrne's model and predictions based upon this model are relatively recent and have not previously been applied to the investigation of abortion patients. The Byrne conceptualization appears to have interesting possibilities for research in regard to first and repeat aborters.

Psychological Characteristics Associated with Abortion

The majority of research concerning abortion in North America has concentrated on the psychological sequelae of abortion, legal or illegal. Relatively little research has focused on repeat abortion; consequently little is known about the psychological and psychosocial characteristics of women who seek repeated abortion.

Several earlier writers asserted their clinical opinion that women who sought an abortion were emotionally ill on the basis of their desire to terminate their pregnancy (Bolter, 1962; Dunbar, 1954; Galdston, 1958; Simon, Rothman, Goff, & Senturia, 1969). However, methodologically sound studies have demonstrated that abortion patients are no more neurotic than a comparable group of non-pregnant women (Kane, Lachenbruch, & Lipton, 1973) and no more psychopathological than women who deliver term pregnancies (Brewer, 1977a). Shusterman (1976), in a critical review of the abortion literature, concluded that there is no evidence to suggest that women who seek abortion to terminate undesired pregnancies are emotionally unstable.

One of the major controversies regarding repeated abortion seeking is whether women are using abortion as a backup or as an alternative to contraception (Bracken, Hachamovitch, Grossman, 1972; Widholm, Kantero, & Rautanen, 1974). Reports from several studies indicate that from 24 to 61 percent of the women applying for a repeat abortion were not using contraception during the month they conceived (Bracken, Hachamovitch, & Grossman, 1972; Bracken & Kasl, 1975b; Brewer, 1977b; Daily et al., 1973; Rovinsky, 1972; Watt, 1974). Some investigations have shown that repeaters and first aborters do not demonstrate significantly different rates of contraception (Bracken, Grossman, & Hachamovitch, 1972; Bracken, & Kasl, 1975b). Four other studies from the United States have shown that groups of women seeking repeat abortions have higher rates of contraceptive practice than those seeking their first abortion (Becker, Note 9; Bracken, Hachamovitch, & Grossman, 1972; Daily et al., 1973; Schneider & Thompson, 1976).

Furthermore, two studies have reported that repeaters were more likely than first aborters to have used the more effective, coitus-independent methods, the pill and IUD, than the less effective methods such as the diaphragm, condom, cream, foam, douche, rhythm, and withdrawal (Bracken & Kasl, 1975b; Schneider & Thompson, 1976). It cannot be concluded from the conflicting findings of these studies whether repeaters are using abortion as a substitute for contraception. The question that still remains is why many women who have experienced an unwanted pregnancy and have terminated it by abortion would expose themselves to a further undesired pregnancy and a repeat abortion which can

be disturbing and expensive, and may present psychological discomfort and medical risks.

One set of variables that appear to be associated with the erratic use (Brewer, 1977b) and non-use of contraception (Bracken, Hachamovitch, & Grossman, 1972; Robert, 1972; Szabady & Klinger, 1972) among recidivists is the nature of the interpersonal relationship. Brewer (1977b) investigated women having their third legal abortion, comparing consistent contraceptive users who had experienced a method failure with women who had been erratic in their contraceptive behavior. The erratic contraceptive category was broad, including women who missed pills, relied on withdrawal, or had unprotected coitus on any occasion between their last two abortions. Brewer found that significantly more of the unmarried women in the erratic group had undergone a change in sexual partners between their second and third abortion than women in the consistent contraception category. Similarly, Bracken, Hachamovitch, and Grossman (1972) reported that repeaters, when compared with first aborters, tended to have experienced a change in their relationship with their partners prior to their unplanned pregnancy.

In Hungary, Szabady and Klinger (1972) found that women having a repeat abortion were less likely to be in a happy marriage, and more likely to have made their decision to have an abortion independently of their partners than were first aborters. More recently, Bracken and Kasl (1975b) noted a tendency for repeaters to have been in a relationship with their partner for a shorter duration than first aborters. Thus the available evidence suggests that the quality and duration of

the interpersonal relationship may be important factors associated with the risk of repeated undesired pregnancy and repeated abortion.

Based on case reports and clinical opinion, abortion repeaters have been characterized as having low self-esteem, depressive tendencies, feelings of inadequacy, unresolved oedipal complexes, intrapsychic conflicts, and self-destructive tendencies (Fischer, 1974; Milojević, Dramusić, Milosavljević, & Lazić, 1972; Robert, 1972). However, to date no methodologically sound studies have established that such factors are in fact characteristic of abortion recidivists.

Controlled studies have found other psychological characteristics to be associated with repeat abortion seeking. Rovinsky (1972), concerned with a 5 percent incidence rate of repeat abortion seeking within the first year of New York's liberalized abortion code, investigated whether differences in impulsivity would differentiate first aborters from repeaters. Repeaters had significantly higher impulsivity scores as assessed by the Porteus Maze Test than first aborters matched for intelligence. Rovinsky characterized repeaters as having "impulsive behavior patterns, absence of reflectiveness, inability to foresee consequences and a reduced capacity to plan ahead on directed tasks" (p. 655).

Effective contraceptive behavior has been shown to be related to a sense of personal control (Fox, 1977; Groat & Neal, 1967, 1973; Lundy, 1972; Meyerwitz & Malev, 1973). An internal locus of control has been shown to characterize young, unmarried women who were contracepting (MacDonald, 1970) while an external locus of control has been reported for unmarried, pregnant adolescents (Meyerwitz & Malev, 1973). Similar-

ly, Groat and Neal (1967, 1973) found an association between poor contraceptive use and a high degree of perceived powerlessness in their studies of married women.

In contrast, two studies have failed to demonstrate an association between locus of control and contraception (Gough, 1973; Harvey, 1976). It appears that problems intrinsic to these studies can account for their results. Nearly 30 percent of the respondents in Harvey's (1976) study failed to answer some or all of the items on the Rotter Scale. Gough (1973) asked his subjects to merely indicate the acceptability of various methods of contraception as opposed to their actual use of contraceptive techniques.

Two studies have applied the Rotter Scale to the investigation of abortion patients (Bracken & Kasl, 1975b; Lynch, 1973). Bracken and Kasl compared repeaters to first aborters using the Internal-External Measure, and found no significant differences between the groups when matched for length of gestation; however, the authors used only eight items from the original 24 item scale. Lynch matched 30 women seeking a first abortion to 30 never-pregnant controls and found no difference between the two groups. However, 50 percent of the control group had never experienced coitus. Thus failure to adequately match the groups on previous sexual experience may have contributed to Lynch's failure to obtain significant differences between her groups. Additional research is needed to determine the efficacy of the internal-external dimension in the study of repeat abortions.

Sex Role Attitudes

Sex-role attitudes have been frequently shown to relate to family planning (Allgeier, 1975; Clarkson, Vogel, Broverman, Broverman, & Rosenkrantz, 1970; Davis, 1967; Fawcett, 1970; Hoffman & Wyatt, 1960; Pohlman, 1969; Pratt & Whelpton, 1958; Rainwater, 1960; Ridley, 1959; Russo & Brackbill, 1973; Scanzoni, 1975). The general finding has been that the less a woman identifies with traditional female roles, the smaller the family size she desires.

More recently investigators have studied the relation between sex-role attitudes and contraceptive use (Fox, 1977; Goldberg, 1974, 1975). Fox reported that nontraditional sex-role attitudes in conjunction with an internal locus of control orientation predicted effective contraceptive behavior. Investigations of Turkish and Mexican women have also shown that nontraditional sex-role attitudes are associated with effective contraception (Goldberg, 1974, 1975). To date, no research has been reported that has compared first and repeat aborters on sex-role attitudes.

Religion

Earlier studies in both the United States* and Canada had demonstrated that Catholics were more likely to disapprove of abortion than noncatholics (Balakrishnan, Ross, Allingham, & Kantner, 1972; Blake, 1971; Boyd & Gillieson, Note 10; Greenglass, 1972; Henriprin & LaPierre-Adamcyk, 1974; Westoff, Moore, & Ryder, 1969). More recent investigations indicate that Catholic and noncatholic attitudes are converging. Studies in the United States have also reported that earlier differences in

fertility and contraceptive practice between Catholics and noncatholics have been decreasing (Westoff & Jones, 1977). Westoff and Bumpass reported as early as 1973 that fertility and contraceptive practices of Catholics were similar to noncatholics. Similarly, in Canada the birth rate of French Canadian Quebecers has declined to the point where it is lower than that of English Canadians (Badgley et al., 1977). It now appears that level of education and degree of religiosity in association with religious affiliation are stronger predictors of attitudes toward abortion than religion alone (Bardis, 1975; Hedderson, Hodgson, Bogan, & Crowley, 1974; Petersen & Mauss, 1976).

Present Study

The main purpose of this study was to further an understanding of the psychological characteristics of women who have first and repeat abortions. This was attempted by extending Byrne's (Byrne et al., 1977) conceptualization of the erotophobia-erotophilia continuum to the study of abortion patients.

As specified above, Byrne outlined four essential steps necessary for effective contraceptive behavior. The woman must admit that intercourse is likely to occur, acquire the necessary birth control device or information, communicate with her partner regarding contraception and sex, and finally utilize the technique effectively. Byrne suggests that erotophobes' negative attitudes towards sexual matters are strong enough to interfere with their effective use of contraception, although they are not strong enough to inhibit sexual activity. For example, if the attitudes are sufficiently negative, the female may not admit

that intercourse is likely to occur, will not obtain a contraceptive technique, will not discuss sexual matters with her partner, and finally will not use contraception at all. Possibly the woman may prefer to regard sexual activity as spontaneous and beyond control. With less negative attitudes, the sequence may be initiated but not completed. For example, she may admit that coitus is likely to occur but not proceed further to obtain the appropriate device or birth control information. Another possibility is that she may admit that intercourse will occur, acquire birth control devices or techniques but fail to discuss the method or its use with her partner and proceed to have unprotected intercourse. A final possibility is that she will proceed through steps one to three, but fail to use the method effectively or at all. For example, she may delay or skip her oral contraceptive, not count days accurately, fail to use spermicide with her diaphragm, or proceed with intromission before her partner uses the condom. The erotophobic woman's negative attitudes towards sexuality thus are expected to relate to her ineffective use of contraception which in turn can result in unplanned pregnancy. Consequently it can be predicted that women who seek abortion should have more conservative attitudes towards sex roles, sexuality, contraception and abortion than women who use contraception effectively. These contracepting women would appear to be demonstrating erotophilic behavior. By acquiring and using a contraceptive device, they are admitting that intercourse is likely to occur, are taking the necessary steps to acquire contraception, and will be effectively protected during each

coital encounter. Thus, extending from Byrne's work, one would expect that such women would have positive attitudes toward sex-related matters.

Women who have experienced one pregnancy termination and who continue to ignore their birth control needs and fail to adequately contracept again are more likely to be further along the erotophobic continuum than initial aborters. Consequently it was predicted that repeaters would have more conservative attitudes than first aborters.

Although previous investigators have applied the Rotter Internal-External Scale to the investigation of abortion patients (Bracken & Kasl, 1975b; Lynch, 1973), problems intrinsic to these studies' methodologies may have prevented the authors from differentiating between their groups. Accordingly, the present study re-examines the nature of the locus of control for initial and repeat aborters and for contraceptors. Within Byrne's conceptual framework, it is predicted that the women who are actively contracepting will have a more internal locus of control than abortion patients, and that repeaters will be less internal than first aborters.

Byrne (1977a, 1977b) when discussing contraceptive behavior; has suggested that erotophobes have inadequate birth control knowledge, and it has been demonstrated that subjects with high sex guilt acquired less birth control information than those with low sex guilt after exposure to a lecture on birth control (Schwartz, 1973). If the Byrne conceptualization can be extended to abortion behavior, then one would expect that abortion patients would know less about birth control than

contraceptors, and further that repeaters would know less than initial aborters. In addition, it was hypothesized that after exposure to contraceptive counselling, repeaters would acquire significantly less birth control information than first aborters.

Previous literature has indicated that, in general, women who seek abortions do not demonstrate neurotic or psychotic functioning (Brewer, 1977a; Kane et al., 1973; Shusterman, 1976). However, several studies have shown that while within the normal range of functioning, abortion patients show poorer personality adjustment scores in comparison to controls (Greenglass, 1977). Moreover, Adler (1976) has suggested that repeat aborters may be more upset by their abortion than initial aborters. Consequently it was predicted that, while within the normal range, abortion patients would demonstrate poorer personality functioning compared to contraceptive patients, with repeaters showing poorer scores than first aborters. Based on previous reports (Greenglass, 1976, 1977), it was predicted that measures of somatic, affective, and cognitive functioning would differentiate the groups.

A number of studies have suggested that the nature and duration of the interpersonal relationship may contribute to the risk of repeated undesired pregnancy (Bracken, Hachamovitch, & Grossman, 1972; Bracken & Kasl, 1975b; Szabady & Klinger, 1972). It was thus predicted that the abortion patient would have been in her relationship with her partner for a shorter duration than the contraceptive patients, with the repeaters having a relationship of shorter duration than the initial aborters. It was further predicted that the quality of the relation-

ship would be less satisfactory for the abortion patient than for the woman who was practicing contraception, and less satisfactory for the repeater than for the first aborter. Finally, it was predicted that more repeaters would fail to inform their partners about their undesired pregnancy and decision to abort than first aborters.

Methodology

Subjects

The subjects selected for this study were three groups of women who were categorized according to their abortion histories. The first and second groups were composed of women who were having a first abortion and a repeat abortion respectively. The third group consisted of women who had never had an abortion and had chosen the intra-uterine device as a method of contraception.

The abortion subjects were scheduled for a first trimester abortion by the menstrual extraction method at the Pregnancy Termination Unit of the Montreal General Hospital. Of the 544 Anglophone and Francophone women approached, 90 percent agreed to participate in the study. Of these, 42 patients were eliminated as their first language was other than French or English. The repeat abortion group was composed of 95 women, 51 Anglophones and 44 Francophones. The group of women having their first abortion contained 353 patients, 147 Anglophones and 206 Francophones.

The contraceptive group consisted of women who were having intra-uterine devices either inserted or re-inserted, the medical procedure most similar to menstrual extraction. Since the abortion patients undergo situational stress it was necessary that the contraceptive group be tested under similar circumstances. Both menstrual extraction and IUD insertion require disrobing, internal examination and dilation of

the cervix, all of which are associated with stress (Kinch, Note 14).

To obtain a sample of IUD users who would presumably be both representative of IUD users in Montreal, although population data are unavailable, and also comparable to the abortion sample, the IUD women were obtained through the cooperation of agencies representative of those types of agencies that provide IUD insertions. Moreover, all of these cooperating agencies refer women to the Montreal General Hospital for pregnancy terminations. The data were collected at the family planning clinics of two major hospitals, three community health centers, three university health centers, and from the practices of four Montreal gynecologists. Of the 181 women approached, 90 percent agreed to cooperate. A total of 163 contraceptive women were interviewed, of whom 42 were excluded from the study due to their having had a previous abortion. An additional 12 were eliminated as they did not meet the primary language criterion, thus resulting in a contraceptive group of 109 women, 43 Anglophones and 66 Francophones. See Table 1 for the breakdown of subjects according to group and language.

Table 1
Distribution of Subjects by Group
and Language Affiliation

Primary Language	Group		
	Repeaters	Initials	Contraceptors
	n=	n=	n=
Anglophone	51	147	43
Francophone	44	206	66
Total	95	353	109

The general health of the women was good and no patients with gynecological disorders were included in the samples. All women were sexually experienced and had engaged in coitus in the month previous to the interview. The subjects' ages ranged from 14 to 45 years. The average level of education was 13.2 years of schooling. A majority of the women, 59 percent, had had no previous pregnancies; 70 percent were childless. Nearly 22 percent of the sample were currently married, 67 percent were single; about 11 percent were separated, divorced, or widowed. The women's social class was assessed by the Blishen Socioeconomic Index, a scale assessing the status of occupations, standardized on a Canadian sample (Blishen, 1967). This index rates occupations on a scale of one to seven where one is the highest socioeconomic level. Subjects whose occupations fell in categories one to three were classified as middle class, while those whose occupations fell in categories four to seven were classified as working class. Students and housewives could not be classified by this scale and were placed in the third category, unemployed. See Table 2 for demographic characteristics of the study sample.

Table 2
Description of Groups According
to Selected Characteristics

Characteristic	Group		
	Repeaters	Initials	Contraceptors
	n=95	n=353	n=109
Age			
≤ 20	12%	31%	24%
21-30	59%	54%	67%
> 30	29%	15%	9%

Continues

Table 2 Continued

Characteristic	Group		
	Repeaters	Initials	Contraceptors
Years of Education			
≤12	41%	54%	25%
13-16	45%	39%	52%
>16	14%	7%	23%
Occupational Status			
Middle	38%	31%	30%
Working	22%	23%	21%
Unemployed*	40%	46%	49%
Religion			
Catholic	58%	70%	54%
Protestant	20%	17%	19%
Jewish	4%	3%	8%
Other	5%	3%	2%
None	13%	7%	17%
Marital Status			
Never married	56%	68%	72%
Married or ever married	44%	32%	28%
Number of previous pregnancies			
0	0%	67%	83%
1	100%	33%	17%
Number of children			
0	56%	69%	83%
1	44%	31%	17%
Number of miscarriages			
0	95%	94%	93%
1	5%	6%	7%

*This category also includes students and housewives.

Table 3
 Description of this Study's Sample of Patients Obtaining
 Abortions at Montreal General Hospital and of Québec
 Abortion Patients by Selected Characteristics

Characteristic	Montreal General Hospital n=448 ^b	Québec ^a n=5,579 ^c
Age		
< 15	1%	1%
15-19	20%	20%
20-24	35%	29%
25-29	23%	24%
30-34	15%	15%
35-40	5%	8%
> 40	2%	3%
Marital status		
Never married	65%	58%
Married or ever married ^d	34%	41%
Abortion experience		
First	79%	88%
Repeat	21%	12%

^aSource: Statistic Canada. Therapeutic Abortion, 1975, September, 1977.

^bIncludes only women having menstrual extractions.

^cIncludes all types of therapeutic abortions.

^dEver married includes separated, divorced, or widowed.

Note: Percents may not add to 100 because of rounding.

The average length of pregnancy of the 448 abortion patients was 8.04 weeks, ranging from six to eleven weeks. Overall, 52 percent of the women seeking a pregnancy termination reported not having used any form of birth control in the month they conceived. Slightly more than 21 percent reported having had a previous abortion. Of the 95 women seeking a repeat abortion, 66 were having a second, 23 a third, one a fourth, three a fifth, and two were seeking a sixth abortion. There were no significant differences between the length of pregnancy for the first and repeat aborters. As can be seen in Table 3, the sample of abortion patients who participated in this study is fairly representative of the total population of women who obtain abortions in the Province of Quebec.

Measures

The questionnaire battery was composed of standardized measures to test the hypothesis that the abortion groups would contain more erotophobic subjects having more negative attitudes towards sex-related matters than contracepting women who would be more erotophilic. Thus the test battery contained four scales, used in previous research, which measured the subjects' attitudes towards sex roles, sexuality, contraception, and abortion. In addition, a measure of locus of control and a contraceptive knowledge questionnaire were selected to test the hypotheses that the abortion groups would have the more external locus of control and less contraceptive knowledge as postulated by Byrne to be characteristic of erotophobes, than contraceptive women who are more erotophilic. A standardized personality measure was also included.

to test the hypothesis, based on previous research, that abortion patients may show poorer personality adjustment. A brief, structured interview was used to collect demographic data about the subjects.

Attitude Measures

The Traditional Sex-Determined Role Standards Scale (ASR) (Ellis & Bentler, 1973) consists of 38-items in a forced-choice format which measures an individual's approval or disapproval of traditional sex-role standards. The authors have reported that women's scores on the test were significantly associated with intelligence, masculinity, liberalism, nonreligiosity, and opposition to traditional sex-role standards. The internal reliability for females has been reported as .91. Due to the limitations of time and the high reliability, only 19 randomly chosen items of the original 38, were used (see Appendix B). The correlation coefficient between the long and short forms of the test is .92.

The Attitude toward Sex in General Scale (AS) (Tolor & DiGrazia, 1976; Tolor, Rice & Lanctot, 1975) assesses an individual's liberal or conservative attitudes toward sexual expression. Previous research has used this scale to assess the attitudes toward sexual activity held by women at various stages of pregnancy (Tolor & DiGrazia, 1976) and by couples using the temperature rhythm method of birth control (Tolor et al., 1975). The original 15-item scale was converted to a 5-point Likert scale for the purposes of the current study. Test-retest reliability on the revised scale is .76 for a five-week interval; inter-item reliability is .66 (see Appendix C).

The Premarital Contraceptive Attitude Instrument (AC) (Parcel, 1975) is a 25-item Likert scale designed to explore respondents' attitudes toward the use of contraception. Test-retest reliability has been reported as .91 for high school and college students and patients at health centers (see Appendix D).

The Attitude toward Abortion Scale (AA) (Lackey & Barry, 1973) consists of 55-items in a Likert format, which measure liberal or conservative attitudes toward abortion. The concurrent validity of the scale has been established by research that demonstrated a significant correlation between it and previous similar scales and its ability to discriminate between subjects of different cultural backgrounds, between Protestant women and women who held no religious convictions, and between subjects of different ages. Split-half reliability for the scale has been reported as .90. Due to constraints in the amount of time available for assessing subjects in this study and the high split-half reliability of the AA scale, only 28 randomly chosen items of the original 55-item scale, were administered (see Appendix E). The correlation coefficient between the long and short form is .97.

Personality Measures

The Differential Personality Inventory (DPI) (Jackson & Messick, 1970) consists of 432 true-false questions designed to assess a normal individual's degree of emotional disturbance. The DPI yields scores on 27 scales which can be classified into four broad areas of personality functioning; physical complaints, disturbances in interactions with others, and in affective, and cognitive functioning. A shortened

form of the DPI was used for this research, which excluded the scales assessing disturbances in interactions with others. Sixteen scales, assessing functioning in three areas, were retained. The first category assesses physical complaints and includes scales that measure tendencies towards insomnia, headache proneness, health concerns, hypochondriasis, and somatic complaints. The second category measures disturbances in affective functioning and includes scales which assess an individual's degree of broodiness, depression, and self-depreciation. The last category assesses cognitive functioning and measures disorganization of thinking, feelings of unreality, impulsivity, mood fluctuation, neurotic disorganization, panic reaction, and perceptual distortion. The last scale, infrequency, serves as a validity check. Construct validity has been established using college undergraduates as subjects. Significant associations have been demonstrated between subjects' DPI scores and roommates' ratings of the subjects' behavior on a number of dimensions that correspond to the DPI scales. The DPI scores also correlate significantly with self-ratings of traits by the subjects (see Appendix F).

The Internal-External Locus of Control Scale (IE) (Rotter, 1966) assesses individuals' beliefs concerning the extent to which they feel their fate is controlled by outside forces or by their own actions. Construct validity of the scale has been demonstrated in a multitude of field and laboratory investigations. The scale consists of 23-item pairs in addition to six buffer items. The respondent selects the statement that she most strongly believes to be true (see Appendix G).

Mirels (1970) factor analyzed the IE scale and reported the presence of two factors, belief in control over political and world events and belief in control over personal affairs. Both Mirels' scoring (MIE) and the original scoring procedure were employed for the purpose of this investigation (see Appendix G).

Knowledge about Contraception Measure

The Knowledge about Contraceptive Devices and Techniques Test (KCDT) (DelCampo, Note 11; DelCampo, Sporkowski, & DelCampo, 1976) contains 26 multiple-choice items. Test-retest reliability has been established at .89. Internal reliability has also been reported as .86 for a sample of 392 college students. Face validity is assumed as the test deals exclusively with knowledge about contraceptive devices and techniques. Differences in the availability of certain devices between the United States and Canada, removal of specific contraceptives from the market, and technological developments since 1973 necessitated the updating of the KCDT, resulting in a 20-item questionnaire. The test-retest reliability of the revised instrument was established in pilot work as .97 for a three week interval for university students (see Appendix H).

Procedure

Patients were approached as they arrived at the Pregnancy Termination Unit and were escorted to a private interviewing room. An experimenter explained the study in general terms in either English or French and asked the patient to complete a consent form which outlined the study and the voluntary nature of their participation (see Appendix I). A structured 10 minute interview obtained demographic infor-

mation about the woman, her partner, the quality of their relationship, past methods of contraception, future contraceptive plans, length of pregnancy, her feelings about the decision to abort, use or nonuse of contraception at conception, and previous pregnancy history (see Appendix J). Immediately following the interview, patients completed the KCDT, the personality and attitude scales, a task requiring approximately 45 minutes. Subsequent to the test administration, patients were directed to the nursing staff at which point they changed into hospital gowns, had laboratory tests, and contraceptive and abortion counselling. The physician then conducted an internal examination to confirm the pregnancy and performed the menstrual extraction. Before leaving the unit the women were given the KCDT to complete again. The entire hospital visit required approximately three hours.

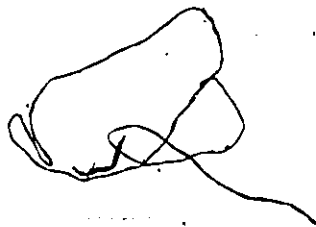
The same procedure was followed for the contraceptive patients at the family planning centers, with the exception that questions relating to the decision to use contraception replaced those questions pertaining to the decision to abort, the KCDT was completed only once, and the IUD insertion replaced the menstrual extraction (see Appendix K). The contraceptive patients did not receive birth control counselling.

Results

Preliminary Analyses

Since this was a study with a correlational design in which the subjects self-selected themselves into their groups, it was necessary to determine how closely the subjects resembled each other on potentially relevant demographic characteristics. The alternative procedure, close matching of the samples a priori, was rejected on the grounds that there was too great a risk that the resultant samples would be atypical of their populations. Thus, the aim of the study was to examine samples that were as comparable to each other as possible but that still retained their representativeness with respect to their parent populations so as to determine the differences in psychological and psychosocial characteristics between the abortion and contraceptive groups. Where necessary, the influence on the dependent measures, if any, of the demographic variables that differentiated between the groups were to be statistically separated.

Statistical analyses revealed that the groups differed significantly on the variables of age, years of education, and number of children, $F(2, 551) = 13.86, p < .001$; $F(2, 551) = 21.08, p < .001$; and $F(2, 551) = 5.55, p < .005$; respectively. There were no significant differences among the groups in socioeconomic status as indexed by the Blishen scale, in marital status, or in religious intensity (see Appendix L for descrip-



tions of the groups). Pearson-product-moment correlation coefficients were computed for age, years of education, and number of children on the DPI subtests, attitude scales, MIE and IE scores, and length and quality of relationship data. Point-biserial correlation coefficients were computed on the data pertaining to whether or not the woman advised her partner about her undesired pregnancy and decision to terminate her pregnancy (refer to Appendix M). The Bonferroni procedure for assessing many correlation coefficients was applied (Larzelere & Mulaik, 1977). Applying Gehring's (1978) criteria for evaluating the magnitude of coefficients, all associations were considered low, with the demographic variables, age, years of education, and number of children, sharing a small amount of the variance with the dependent measures. The only exception to this finding was that length of relationship correlates moderately with age and number of children due to the married women in the samples. Of the three demographic variables years of education showed the greatest degree of association with the dependent variables with the maximum amount of shared variance being 18 percent.

As another assessment of any possible significant effects, a MANCOVA adjusted for years of education was computed on the dependent variables with which education was correlated, the DPI scales and the attitude measures. The tables in Appendix N contain the results for the MANCOVAS. With the exception of three personality scales, the ANCOVAS obtained the same pattern of results as was found in the main analyses of the data although with reduced levels of significance.

Where differences between the main analysis and the supplementary anal-

ysis occurred they will be indicated in the text. MANCOVA was not used for the main technique of data analysis due to the questions concerning its use (Lord, 1967; 1969).

As a further check of the relevance of years of education to the dependent measures of the study, a computer generated matching procedure was used to draw proportionate subsamples of women within each of the six groups, such that these subsamples did not differ in mean or variance on the years of education variable. The results of the analyses for the subsample data were similar to those obtained for the ANCOVAs, that is, the majority of the effects were retained with a reduced level of significance (see Appendix O). Where discrepancies in results from the main analyses occurred they will also be indicated in the text.

Results of the Study

Since many related variables were investigated the main technique of data analysis was multivariate analysis followed by univariate analysis where appropriate, as recommended by Hummel and Sligo (1971). Inspection of the data for skewness, kurtosis, and Bartlett tests of homogeneity of variance indicated that the assumptions of normality and homoscedasticity were not violated. In addition, it should be noted that the multivariate procedure employed in this study has been shown to be robust under a wide variety of conditions (Harris, 1975; Ogilvie, Note 15; Olsen, 1974).

The magnitude of associations among measures was examined in an intercorrelational matrix (see Appendix P). An assessment of the pat-

tern of associations between and within the four sets of measures indicated that MANOVAS should be computed separately for the 15 subscales of the DPI, the four attitude scales, the two IE measures, and the two relationship variables. The design of the study is a 3 x 2 factorial for the variables Group (repeat abortion, initial abortion, contraceptive) and Language (Anglophone, Francophone).

The first set of hypotheses predicted that abortion patients would have more conservative attitudes towards sex roles, sexuality, contraception, and abortion than contraceptive patients and, in addition, that repeaters would have more conservative attitudes than first aborters. The multivariate analysis for the attitude measures shows a significant effect for the variable Group, $F(8, 1082) = 13.64, p < .00001$. The univariate analyses indicate that the groups differ significantly on each of the four attitude scales, $F(2, 554) = 10.11, p < .001$; $F(2, 554) = 22.13, p < .00001$; $F(2, 554) = 29.14, p < .00001$; $F(2, 554) = 7.42, p < .001$ for attitudes towards sex roles, sexuality, contraception, and abortion, respectively (see Table 4 on the following page). As can be seen in Table 5, Scheffé tests of individual comparisons indicate that the two abortion groups differ significantly from the contraceptive group on their attitudes towards sex roles, sexuality, and contraception ($p < .05$), however, the repeaters and initial aborters do not differ between themselves. As predicted, the contraceptive patients hold more favorable attitudes towards egalitarian sex roles, sexuality in general, and contraception. Scheffé tests on the attitude towards abortion means indicate that the repeat abortion group differs significantly from the initial abortion group and the contraceptive group with the latter two groups

Table 4
 Manova Results and Univariate Tests for Attitude Scales

Manova Tests				
Effect	df hyp	df err	F	p
Group	8	1082	13.64	<.00001
Language	4	544	.92	ns
Interaction	8	1082	1.32	ns
Univariate Tests for Group				
Variable	df	F	p	
Sex Roles	2,554	10.11	<.00005	
Sexuality	2,554	22.13	<.00001	
Contraception	2,554	29.14	<.00001	
Abortion	2,554	7.42	<.001	
Univariate Tests for Language				
Variable	df	F	p	
Sex Roles	1,554	.41	ns	
Sexuality	1,554	.05	ns	
Contraception	1,554	.06	ns	
Abortion	1,554	1.85	ns	
Univariate Tests for Group x Language				
Variable	df	F	p	
Sex Roles	2,554	1.49	ns	
Sexuality	2,554	.51	ns	
Contraception	2,554	.19	ns	
Abortion	2,554	.78	ns	

not differing from each other ($p < .05$). However, contrary to the prediction, repeaters hold significantly more favorable attitudes towards abortion than contraceptive and initial abortion patients (Scheffé, $p < .05$). By comparing the data in Table 4 with those in Appendices N and O, it can be seen that all results that are significant on the main

Table 5
Mean Attitude Scores for Groups

Scale			
Sex Roles	16.79 ^a C	<u>15.58</u> ^b R	<u>15.22</u> ^c I
Sexuality	60.58 C	<u>56.73</u> R	<u>55.52</u> I
Contraception	109.38 C	<u>102.66</u> R	<u>99.84</u> I
Abortion	112.82 R	<u>108.08</u> C	<u>106.91</u> I

^aA higher score reflects a more liberal attitude.

^bMeans underlined by the same lines do not differ significantly, Scheffé, $p < .05$.

^cR=Repeat aborters.

I=Initial aborters.

C=Contraceptors.

analyses are also significant on the analyses where level of education was considered with the exception of the attitude towards abortion variable, where the effect appears as a trend ($p < .10$) on the matched subsample analysis. As can be seen in Table 4, there are no significant differences between the Anglophone and Francophone patients on any of the attitude measures. Refer to Appendix Q for means and standard deviations for the attitude measures.

It was hypothesized that women who are seeking abortions would have a more external locus of control than women who are practicing contraception. It was also predicted that repeaters would have a more external locus of control than initial aborters. Inspection of the overall results of the multivariate analysis reveals that the groups do not differ significantly from each other on the IE measures, $F(4, 1084) = 1.04$ (see Table 6 on the following page). The univariate analyses indicate

Table 6
Manova Results and Univariate Tests for Locus of Control Scales

Manova Tests				
Effect	df hyp	df err	F	p
Group	4	1084	1.04	ns
Language	2	542	2.13	ns
Interaction	4	1084	.67	ns
Univariate Tests for Group				
Variable		df	F	p
Rotter's IE		2,543	.94	ns
Mirels' IE		2,543	1.97	ns
Univariate Tests for Language				
Variable		df	F	p
Rotter's IE		1,543	3.19	< .10
Mirels' IE		1,543	.57	ns
Univariate Tests for Group x Language				
Variable		df	F	p
Rotter's IE		2,543	.16	ns
Mirels' IE		2,543	.17	ns

that the groups do not differ significantly from each other on the Rotter's, $F(2, 543) = .94$ nor the Mirels' IE scale, $F(2, 543) = 1.97$. The multivariate analysis indicates that both the effect of the variable Language and the Group x Language interaction are also not significant, $F(2, 542) = 2.13$; and $F(4, 1084) = .67$, respectively (see Appendix R for means and standard deviations for the IE scores).

Two predictions were made involving subjects' knowledge about contraception. The first hypothesis stated that abortion patients would know less about contraception than women who are practicing contraception successfully. It was further predicted that repeaters would know

less than first aborters. The KCDT was completed by 148 abortion patients prior to abortion counselling. A sample of 50 contraceptive patients completed the KCDT just prior to being seen by their physician. Statistical analyses reveal that the groups differ significantly on the variables age, years of education, religious intensity, marital status, and number of children, $F(2, 192) = 8.67, p < .001$; $F(2, 192) = 17.94, p < .001$; $F(2, 192) = 4.25, p < .05$; $\chi^2(5) = 11.94, p < .05$; and $F(2, 192) = 3.97, p < .05$, respectively. The groups do not differ on occupational status (see Appendix S for descriptions of the groups). Pearson-product-moment correlation coefficients were computed for the variables age, years of education, religious intensity, and number of children with subjects' KCDT scores. A point-biserial correlation was computed for the variable marital status with the KCDT scores. All five were related significantly with the KCDT scores (see Appendix T). However, all associations were weak (Gehring, 1978), with the exception of the variable years of education.

A 3 x 2 ANCOVA adjusted for years of education for the variables Group (repeat abortion, initial abortion; contraceptors) by Language (Anglophone; Francophone) was computed on the KCDT scores. As can be seen from Table 7, there is a significant effect for the variables Group and Language, as well as a significant interaction, $F(2, 191) = 5.47, p < .005$; $F(1, 191) = 4.71, p < .05$; and $F(2, 191) = 3.59, p < .05$, respectively. As can be seen in Table 8, Scheffé tests of individual comparisons reveal that, as predicted, the two Anglophone abortion groups know less about birth control than the women who are visiting their physician in regards to contraception ($p < .05$), however, the two abor-

Table 7
Summary Table for Analysis of Covariance of KCDT Scores
Adjusted for Years of Education as a Function
of Group and Language

Source	SS	df	MS	F	p
Group	103.90	2	51.95	5.47	<.005
Language	44.79	1	44.79	4.71	<.05
Group x Language	68.15	2	34.08	3.59	<.05
Error	1815.41	191	9.51		

tion groups do not differ between themselves. The French initial aborters know significantly less about contraception than the contraception group (Scheffé, $p < .05$), however, the repeaters do not differ from either of the two former groups.

The second hypothesis in regards to birth control information posited that repeaters would acquire significantly less contraceptive knowledge than first aborters from the contraceptive counselling sessions. Statistical analyses were performed for the dependent variables age, years of education, intensity of religion, marital status, and number of children for the 137 abortion patients who completed the KCDT both before and after contraceptive counselling. The groups do not differ on the variables years of education, intensity of religion, marital status, occupational status nor number of children (refer to Appendix U). The two abortion groups differed significantly from each other on the variable age, $F(1, 133) = 10.50$, $p < .005$, but the associations between age and the before and after counselling KCDT scores were not significant, $r = .14$ and $.06$, respectively.

Table 8
Mean KCDT Scores for Variable Group for
Abortion and Contraceptive Patients

Language			
Anglophones	13.11 ^a	<u>8.00^b</u>	<u>7.64^c</u>
	C	R	I
Francophones	9.93	<u>8.53</u>	<u>7.03</u>
	C	R	I

^aA higher score reflects more contraceptive knowledge.

^bMeans underlined by the same line do not differ significantly, Scheffé, $p < .05$.

^cR=Repeat abortion.

I=Initial abortion.

C=Contraceptor.

A 2 x 2 ANOVA for the variables Group (repeat abortion, initial abortion) by Language (Anglophone, Francophone) was computed on the subjects' before counselling KCDT scores. The analysis revealed no significant effects for the variables Group, Language, nor for the Group x Language interaction, $F(1, 133) = .65$, $F(1, 133) = .81$, $F(1, 133) = 3.01$, respectively.

Table 9
Summary Table for Analysis of Variance of KCDT Difference
Scores as a Function of Group and Language

Source	SS	df	MS	F	p
Group	.01	1	.01	.01	ns
Language	11.00	1	11.00	2.25	ns
Group x Language	7.20	1	7.20	1.47	ns
Error	650.60	133	4.89		

As the groups did not differ on their initial KCDT scores, a difference score was computed by subtracting the subjects' first KCDT scores from their second KCDT scores to assess the amount of information acquired. A 2 x 2 ANOVA for the variables Group and Language was computed on the difference scores.

As can be seen in Table 9, analysis reveals no significant effects for the variables Group, Language, nor for the Group x Language interaction, $F(1, 133) = .01$; $F(1, 133) = 2.25$; $F(1, 133) = 1.47$, respectively. Thus the initial and repeat aborters do not differ on the amount of information acquired from the contraceptive counselling. See Appendix V for means and standard deviations for the before and after KCDT scores.

The next prediction was that abortion patients would demonstrate poorer personality functioning on scales assessing physical concerns, affective states, and cognitive functioning than contraceptive patients, with repeaters showing poorer adjustment than initial aborters. The multivariate analysis for the DPI subscales shows significant effects for the variables Group and Language, $F(30, 1074) = 2.34$, $p < .0001$, and $F(15, 537) = 4.49$, $p < .00001$, respectively (see Table 10).

Table 10
Manova Results for DPI Scales

Manova Tests				
Effect	df hyp	df err	F	p
Group	30	1074	2.34	<.0001
Language	15	537	4.49	<.00001
Interaction	30	1074	.79	ns

The univariate analyses indicate that the variable Group is significant for eight of the 15 personality measures. The first category of personality functioning is that of physical concerns and is composed of five subscales. The univariate analyses indicate that the groups differ significantly on the insomnia, $F(2, 551) = 7.52, p < .001$; somatic complaints, $F(2, 551) = 8.76, p < .0001$; headache proneness, $F(2, 551) = 3.39, p < .05$; health concerns, $F(2, 551) = 11.73, p < .00001$; and hypochondriasis, $F(2, 551) = 10.35, p < .00005$ subscales. The univariate analyses for the variable Group are listed in Table 11.

Table 11
Univariate Tests for DPI Scales for Group

Variable	df	F	p
Physical Complaints			
Insomnia	2,551	7.52	<.001
Headache proneness	2,551	3.39	<.05
Health concerns	2,551	11.73	<.00001
Hypochondriasis	2,551	10.35	<.00005
Somatic complaints	2,551	8.76	<.0001
Affective adjustment			
Broodiness	2,551	2.73	<.10
Depression	2,551	2.21	ns
Self depreciation	2,551	1.57	ns
Cognitive functioning			
Disorganization of thinking	2,551	4.77	<.01
Feelings of unreality	2,551	.99	ns
Impulsivity	2,551	.98	ns
Mood fluctuation	2,551	.76	ns
Neurotic disorganization	2,551	.28	ns
Panic reaction	2,551	5.70	<.005
Perceptual distortion	2,551	6.41	<.005

As predicted, the abortion groups have significantly more elevated scores than the contraceptive group on the insomnia, health concerns, and somatic complaints subscales (Scheffé, $p < .05$); however, contrary to prediction, the two abortion groups do not differ from each other. The initial abortion group has significantly poorer scores than the contraceptive group on the headache proneness and hypochondriasis subscales as predicted (Scheffé, $p < .05$); however the repeat aborters' mean score is intermediate between the initial aborters and contraceptive subjects and does not differ significantly from either (see Table 12).

When the effects of education are controlled for by ANCOVAs and by the matched subsamples analyses four of the five measures maintain significance, while the fifth measure, headache proneness, is no longer statistically significant.

The next category of personality measures assesses an individual's affective state. Inspection of the univariate analyses in Table 10 indicates that the groups do not differ significantly for any of the three variables in this category. These results are consistent with the ANCOVAs and matched subsample analyses.

The last category of the DPI, consisting of seven scales, examines disturbances in cognitive functioning. The univariate analyses indicate that the groups differ significantly on the scales measuring disorganization of thinking, $F(2, 551) = 4.77$, $p < .01$; panic reaction, $F(2, 551) = 5.70$, $p < .005$; and perceptual distortion, $F(2, 551) = 6.41$, $p < .005$. Scheffé tests of individual comparisons indicate that the abortion patients, as predicted, have significantly poorer scores than contraceptive patients on the disorganization of thinking scale ($p < .10$). Con-

Table 12
Mean DPI Scores for Groups on Significant Scales

Scale			
Somatic Complaints			
Insomnia	<u>3.52^a</u> R ^c	<u>3.18^b</u> I	-2.40 ** C
Headache proneness	<u>1.96</u> I	<u>1.95</u> R	1.35 ** C
Health concerns	<u>7.51</u> I	<u>7.28</u> R	5.93 ** C
Hypochondriasis	<u>3.57</u> I	<u>3.19</u> R	2.37 ** C
Somatic complaints	<u>4.47</u> R	<u>4.31</u> I	3.13 ** C
Cognitive Functioning			
Disorganization of thinking	<u>2.61</u> R	<u>2.58</u> I	1.72 * C
Panic reaction	<u>5.64</u> I	<u>5.01</u> R	4.50 ** C
Perceptual distortion	<u>4.56</u> I	<u>4.01</u> R	3.63 ** C

^aA higher score reflects a poorer adjustment

^bMeans underlined by the same line do not differ significantly,

Scheffé, $p < .10$.*

Scheffé, $p < .05$ **

^cR=Repeat aborters.

I=Initial aborters.

C=Contraceptors.

trary to the prediction, however, the scale does not differentiate the two abortion groups. The initial abortion group has poorer scores on the panic reaction and perceptual distortion scales than women practi-

ing contraception (Scheffé, $p < .05$). However, the repeat abortion group does not differ significantly from either of the former groups. There are no differences among the groups on the subscales which measure an individual's feelings of unreality, impulsivity, mood fluctuation, and neurotic disorganization, $F(2, 551) = .99$; $F(2, 551) = .98$; $F(2, 551) = .76$; and $F(2, 551) = .28$, respectively. None of the cognitive functioning variables reach significance for both the ANCOVA and the matched subsample analyses. The variable panic reaction remains significant for the matched subsamples, while the perceptual distortion variable is significant for the ANCOVA.

As stated earlier the multivariate analysis indicates a significant effect for the variable Language, $F(16, 536) = 4.29$, $p < .00001$. As can be seen in Table 13, the univariate tests indicate that the variable Language is significant for 10 of the 15 subtests; insomnia, $F(1, 551) = 4.15$, $p < .05$; somatic complaints, $F(1, 551) = 4.21$, $p < .05$; hypochondriasis, $F(1, 551) = 20.43$, $p < .00001$; broodiness, $F(1, 551) = 15.58$, $p < .0001$; self depreciation, $F(1, 551) = 6.28$, $p < .05$; disorganization of thinking, $F(1, 551) = 9.83$, $p < .005$; feelings of unreality, $F(1, 551) = 29.01$, $p < .00001$; panic reaction, $F(1, 551) = 10.12$, $p < .005$; impulsivity, $F(1, 551) = 6.03$; $p < .05$; and perceptual distortion, $F(1, 551) = 30.99$, $p < .00001$. Scheffé tests indicate that the Francophone subjects have significantly higher scores than the Anglophones, ($p < .05$). On all the remaining scales the Francophone group also scores higher, though not significantly so, demonstrating a consistent pattern across all DPI subscales.

There are no significant interactions between the variables Group and

Table 13
Univariate Tests for DPI Scales for Language

Variable	df	F	p
Physical Complaints			
Insomnia	1,551	4.15	<.05
Headache proneness	1,551	.03	ns
Health concerns	1,551	1.79	ns
Hypochondriasis	1,551	20.43	<.00001
Somatic complaints	1,551	4.21	<.05
Affective adjustment			
Broodiness	1,551	15.58	<.0001
Depression	1,551	.29	ns
Self depreciation	1,551	6.28	<.05
Cognitive functioning			
Disorganization of thinking	1,551	9.83	<.005
Feelings of unreality	1,551	29.01	<.00001
Impulsivity	1,551	6.03	<.05
Mood fluctuation	1,551	.72	ns
Neurotic disorganization	1,551	2.05	ns
Panic reaction	1,551	10.12	<.005
Perceptual distortion	1,551	30.99	<.00001

Language for any of the DPI scales. Table 14 contains the univariate tests for the DPI subscales for the Group x Language interaction. Refer to Appendix W for the means and standard deviations for the DPI scores.

The next group of hypotheses focuses on the quality and duration of the interpersonal relationship. It was predicted that abortion subjects would have been in a relationship with their partners for a shorter period of time than contraceptors, with the repeaters reporting a shorter duration than the initial aborters. It was also predicted that abor-

tion patients would report having less satisfactory relationships than contraceptors with repeaters having the least satisfactory involvements. The multivariate analysis on the variables that assess the interpersonal relationship shows a significant effect for the variable Group, $F(4, 1074) = 5.97$, $p < .0001$ (see Table 15). The univariate test on the dependent variable, quality of relationship is significant, $F(2, 538) = 11.20$, $p < .00005$. There are no differences between the groups on the variable length of involvement, $F(2, 538) = .24$. Contrary to the prediction,

Table 14
Univariate Tests for DPI Scales for Group x Language

Variable	df	F	p
Physical complaints			
Insomnia	2,551	.72	ns
Headache proneness	2,551	1.46	ns
Health concerns	2,551	.12	ns
Hypochondriasis	2,551	1.01	ns
Somatic complaints	2,551	.06	ns
Affective adjustment			
Broodiness	2,551	.35	ns
Depression	2,551	.73	ns
Self depreciation	2,551	1.64	ns
Cognitive functioning			
Disorganization of thinking	2,551	.21	ns
Feelings of unreality	2,551	.19	ns
Impulsivity	2,551	.18	ns
Mood fluctuation	2,551	.54	ns
Neurotic disorganization	2,551	.57	ns
Panic reaction	2,551	.02	ns
Perceptual distortion	2,551	2.18	ns

the quality of the relationship of the contraceptive patients is not significantly different from either of the two abortion groups. However, as predicted, the initial aborters report having a better quality relationship than repeat aborters (Scheffé, $p < .05$). The means and standard deviations for the relationship variables are in Appendix X.

The last predictions deal with only the abortion patients. It was predicted that significantly less repeaters than first aborters would inform their partners about their undesired pregnancies and their decision to abort. Contrary to the prediction, Chi square analyses reveal no significant differences between the proportion of first and repeat aborters who informed their partners about their pregnancies, nor about their decision to abort, $\chi^2(3) = 1.09$, $p > .05$, and $\chi^2(3) = 2.81$, $p > .05$, respectively (see Tables 16 and 17).

Table 15
 Manova Results and Univariate Tests for Length and
 Quality of Relationship

Manova Tests				
Effect	df hyp	df err	F	p
Group	4	1074	5.97	<.0001
Language	2	537	2.09	ns
Interaction	4	1074	2.22	<.10
Univariate Tests for Group				
Variable	df	F	p	
Length	2,538	.24	ns	
Quality	2,538	11.20	<.00005	
Univariate Tests for Language				
Variable	df	F	p	
Length	1,538	.41	ns	
Quality	1,538	4.06	<.05	
Univariate Tests for Group x Language				
Variable	df	F	p	
Length	2,538	2.69	<.10	
Quality	2,538	1.43	ns	

Table 16
The Relation Between Abortion Group and
Informing Partner about Pregnancy

Told Partner	Group			
	Repeat		Initial	
	Anglophone	Francophone	Anglophone	Francophone
No	15.7% (8)	15.9% (7)	17% (25)	13.1% (27)
Yes	84.3% (43)	84.1% (37)	83% (122)	86.9% (179)
	100% (51)	100% (44)	100% (147)	100% (206)

$\chi^2 = 1.09$, $df = 3$, $p > .05$.

Table 17
The Relation Between Abortion Group and
Informing Partner about Abortion

Told Partner	Group			
	Repeat		Initial	
	Anglophone	Francophone	Anglophone	Francophone
No	17.6% (9)	20.5% (9)	20.4% (30)	14.1% (29)
Yes	82.4% (42)	79.5% (35)	79.6% (117)	85.6% (177)
	100% (51)	100% (44)	100% (147)	100% (206)

$\chi^2 = 2.81$, $df = 3$, $p > .05$.

Discussion

The main purpose of this investigation was to further an understanding of the psychosocial and psychological characteristics of women who seek a first trimester abortion, be it a first or repeat abortion. Furthermore, an attempt was made to differentiate initial and repeat aborters and contraceptors on a number of selected variables.

The extension of the Byrne dimension of erotophilia-erotophobia to the study of women seeking abortion was largely supported (Byrne, 1977a; Byrne et al., 1977). It was shown that women who seek abortions are more erotophobic than women who are successfully practicing contraception, and who have never had an abortion. As was predicted from the Byrne model, women who seek an abortion have more conservative attitudes towards sex roles, sexuality, and contraception. In addition, they know less about birth control than contraceptors.

Extrapolating from the Byrne model led to the prediction that abortion patients would hold less favorable attitudes towards abortion than the control group. Contrary to the study's prediction, however, the attitudes towards abortion of the repeat abortion group were more favorable than those of the contraceptive group. It is possible that, at least prior to their abortion-seeking behavior, the women in both abortion groups had held less favorable attitudes towards abortion, which would have been consistent with their more unfavorable attitudes towards other sex-related topics. There is some support for this conjecture as it has been reported that more than 46 percent of the wo-

men seeking a first abortion were certain that they themselves would never have an abortion (Freeman, 1978). If the abortion groups did in fact hold more unfavorable attitudes towards abortion, these women would have chosen to engage in behavior which ran counter to their attitudes. Consequently, for many women the abortion decision contradicts their self-perception. According to cognitive dissonance theory (Aronson, 1968; Festinger, 1957), such behavior, discrepant from attitude, produces cognitive dissonance. According to Festinger, the three ways of reducing dissonance are changing one's behavior, changing one's environment to one that presents factors that are consonant with one's behavior, or adding new cognitive elements to support one's decision. Festinger predicts that it is the least heavily weighted element in the dissonance situation that is most likely to be changed. Choosing the first two alternatives for the pregnant woman presents difficulties. To choose to have a child is a major decision affecting all areas of her life. Similarly, it is often impossible for a woman to alter her environment to one more conducive to her having a child. Of the three alternatives, a change in her attitude towards abortion is the most likely to occur. Additional support is provided for this explanation by evidence within this investigation. It was found that repeat abortion patients held significantly more favorable attitudes towards abortion than initial aborters, possibly indicating that a repeat abortion further increases dissonance and produces further attitude change.

The similarity across linguistic groups on the attitude measures is consistent with a recent study which reported that Francophone and

Anglophone women did not differ on their attitudes towards sex roles (Gold & Andres, Note 12). Similarly, other studies have found great similarities between Catholic and noncatholic fertility and contraceptive practices (Badgley et al., 1977; Westoff & Jones, 1977).

Support was gained for the prediction that contraceptive women would know more about birth control than the abortion patients. Contrary to prediction, the initial abortion patients did not acquire significantly more birth control information than repeaters from the contraceptive counselling. Since the contraceptive group holds more favorable attitudes towards contraception, while the initial and repeat aborters do not differ from each other in their more conservative attitudes, the knowledge about birth control results are consistent with the attitude findings.

Byrne has suggested that erotophobes are more likely to have a more external locus of control than erotophiles (Byrne et al., 1977). Other researchers have sought to test the relevance of the locus of control dimension in investigations of abortion patients and, as is the case in this investigation, failed to differentiate between their respective groups (Bracken & Kasl, 1975b; Lynch, 1972). Many researchers have suggested that the IE measure is too general and that an individual's perception of control varies from situation to situation (MacDonald & Tseng, Note 13; Mirels, 1970; Viney, 1974). Fox (1977) found that the IE measure by itself was not sufficient to predict contraceptive behavior. However, an internal locus of control in conjunction with an egalitarian sex-role orientation was. It appears, therefore, that the IE measure is not sufficient by itself for dif-

ferentiating between abortion and contraceptive patients.

On the basis of the findings by Greenglass (1976) it was expected that abortion patients would demonstrate poorer physical, affective and cognitive adjustment than the contraceptive patients. While some of the scales of the DPI differentiate the contraceptive patients from the initial abortion group and in some cases from the repeaters, as was predicted, all scores are within the normal range of personality functioning. The physical complaint scales differentiate the groups the most distinctively of all the DPI categories, with all of the scales differentiating the contraceptive patients from the initial aborters and with three of these also differentiating the former from repeaters. None of the affective scales, broodiness, depression, and self-depreciation differentiate the groups. The results of the three analyses on the cognitive functioning scales are somewhat inconsistent in differentiating the groups. Therefore, any conclusions concerning differences in cognitive functioning among these patients should be drawn very cautiously. Although the results of this study are similar to those reported by Greenglass, in that the women's scores are within the normal range of personality functioning, they are contrary to her report of poorer affective functioning of the abortion women as compared to control groups. Major methodological differences between the studies may account for the differing results. The chief of these differences is that Greenglass relied predominantly on advertisements to recruit volunteers who were tested an average of 36 weeks post abortion, some of whom had had concurrent

hysterectomies and some of whom had had the more stressful saline abortion. All of these factors could contribute to her obtaining a more distressed sample of abortion patients.

The DPI manual describes its subscales in terms of specific traits (Jackson & Messick, 1971), that is specific characteristics of the individual that are relatively consistent over time. If approached from a trait theorist's viewpoint, the interpretation can be made that initial abortion patients, and in some cases repeaters, are more prone to physical complaints such as difficulty with sleeping, more frequently have headaches, are more preoccupied with their physical health and well-being and are prone to physical difficulties more frequently than women who are practicing birth control. Moreover, they are more easily scared, confused, and prone to misinterpret what they see and hear.

Inspection of the pattern of significant results within a situation specific context of when and where the test was taken leads to an alternative explanation. It has been suggested that a great many of the characteristics that psychologists assess are more properly viewed as states rather than traits, which fluctuate over time and from situation to situation (Tyler, 1974). A more parsimonious explanation may be that the initial abortion patients, and in some instances, the repeaters are exhibiting a stress reaction to their anticipation of the abortion procedure. Consequently, the small but significant elevation on the physical complaints scale reflects their concern with their physical well-being as they approach the abortion procedure. Within this framework they are more easily confused, scared, and disorganized than a

group of women visiting a doctor for a routine gynecological examination.

The pattern of results of the repeaters also supports this explanation. While the initial abortion and contraceptive patients differ from each other on eight out of 15 scales, the repeaters differ from the contraceptors on only four of these same scales and can be seen as being intermediate to the initial abortion and contraceptive groups. The state hypothesis would explain these findings by arguing that having had a previous abortion and having gained some familiarity with the situation, repeaters are not as easily scared, confused, or upset by the abortion procedure. In addition, the fact that their attitudes are more favorable to abortion than the initial aborters might put them more at ease just prior to the procedure. Whatever the contributions of the situational pressures may be to the DPI scores, it is quite clear that this group of patients who are seeking abortions are not functioning pathologically. A different pattern of results might be expected in the study of late abortion patients.

The rather consistent pattern of differences between the Franco-phone and Anglophone groups across the DPI subscales requires commenting. Jackson, the first author of the DPI, discussing a second personality measure with English and French forms, states that while the same factor pattern emerges for both groups caution must be exercised when comparing actual scores between the two language versions (Skinner, Jackson, & Rampton, 1976). It appears that this study's findings of consistent differences between the language groups is reflective of differences in cultural norms. Consequently, the higher scores of the

Francophone subjects should not be viewed as a greater stress reaction but rather seen as reflecting a different baseline.

As was stated earlier in the discussion, one of the purposes of this investigation was to differentiate initial and repeat aborters. Of a possible 27 comparisons only the attitude towards abortion and quality of relationship variables differentiate the two abortion groups from each other, with only the latter being in the predicted direction. In addition, a greater proportion of subjects within the repeat abortion group were using contraception than those in the initial abortion group; otherwise the two groups were essentially similar. Future attempts to differentiate the repeat abortion patient on psychological characteristics do not appear likely to be profitable.

Future research attempts could more profitably consider certain basic dimensions which might differentiate in a similar fashion within each of the initial and repeat abortion groups. This suggests that both abortion groups consist of a heterogeneous sample of patients. On one hand there would be a group of women, erotophiles, who hold positive attitudes towards sexuality, contraception, abortion and egalitarian sex-roles. These women would take measures to protect themselves from undesired pregnancy yet experience a contraceptive failure due to the technological limitations of the current birth control techniques and devices. A second subgroup of women could be composed of erotophobes, who possess negative attitudes, fail to use contraception, and consequently experience undesired pregnancies.

There is some support for this assumption. A MANOVA was computed

for the attitude scores of the noncontraceptors and contraceptors within the initial and repeat abortion groups. The contraceptive category was broad and included women using the IUD, oral contraceptive, vaginal spermicides, diaphragm, as well as couples using rhythm, withdrawal, or condoms. There are significant differences between noncontraceptors and contraceptors in both the initial and repeat abortion groups. Noncontraceptors hold significantly less favorable attitudes towards contraception and abortion than contraceptors, $F(1,434) = 13.61$, $p < .0005$ and $F(1,434) = 7.97$, $p < .005$, respectively. In addition, inspection of the means of the attitude towards sex roles and sexuality measures indicate that noncontraceptors have less egalitarian and favorable attitudes than contraceptors (see Appendix Y).

This could be expected from extension of both the Byrne and Tietze models. While Byrne posits that contraceptors would have such favorable attitudes, Tietze would add that due to inherent technological limitations and inevitable human error large numbers of undesired pregnancies are to be expected even among contracepting women.

Bracken and Kasl (1975b) discuss a third group from within repeat abortion groups. They suggest that there is a group of women who experience contraceptive failure due to social and personal interactions that are not conducive to the effective use of birth control. It is likely that the initial abortion group also contains such women. It would appear that these women occupy an intermediate position along the erotophobe-erotophile continuum of abortion patients.

This explanation that there are similar subgroups within repeat and initial abortion samples, as is suggested by this study's post hoc ana-

lyses, requires replication. Nonetheless, such an explanation has worthwhile implications for the contraceptive counselling of abortion patients. The three subgroups of abortion patients, women who are using contraception, women who fail to use contraception, and a third group whose use of contraception is interfered with by interpersonal pressures, as is suggested by Bracken and Kasl (1975b), would require different counselling techniques. The first group, who are probably adequately motivated, would require only supplementary information so as to more effectively use contraception. Counselling for them would probably be circumscribed and brief. The second group would require more extensive professional counselling, including attempts to change attitudes and to foster their ability to foresee consequences of their behavior so as to motivate them to use contraception, as well as information about contraceptive techniques. In addition, this group would probably benefit from individual counselling, immediate provision for contraception, preferably a coitus-independent method, and prearranged follow-up visits. The last group would require counselling which includes information not directly related to birth control. Such an approach would encompass training to deal with interpersonal pressures effectively. In addition, they would probably benefit from counselling directed at improving their motivation to contracept more effectively and consistently, as well as additional birth control information. This approach would be particularly relevant for the counselling of repeat abortion patients who have been found by this and other studies to have unsatisfactory interpersonal relationships (Bracken, Hachamovitch, & Grossman, 1972; Szabady & Klinger, 1972).

It is important to emphasize that the findings of this investigation contradict the stereotypic image of the abortion patient as an individual with somewhat psychopathic characteristics who uses abortion as a means of birth control. Instead it appears that contracepting women use abortion as a backup for contraceptive failure and in the case of the noncontraceptor, as a solution to a pregnancy whose possibility was neither anticipated nor precluded. It appears that this second group of women are pregnant not because of their erotophilic tendencies, but rather because of their "erotophobic attitudes.

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Appendices

Appendix A

Tietze's Formulae Used to Predict Repeat Abortion Seeking

Selected Measures of Repeat Abortion Frequency^a

Three measures of the expected frequency of repeat abortions were estimated by the following formulae, reflecting the assumptions stated in the text:

$$R = 100 \left\{ 1 - \left[1 - F(1-E) \right]^{\frac{N-D}{3}} \right\}$$

$$R' = \frac{100 (N - D)}{3 + 1/F(1 - E)}$$

$$R'' = \frac{100(N - 6 - D)}{(N - 6) + 1/F(1 - E)}$$

R=Percent of women having at least one repeat abortion to end of Nth year.

R'=Repeat abortions per 100 women to end of Nth year.

R''=Repeat abortions per 100 total abortions during Nth year of availability.

F=Fecundability per month of unprotected exposure to risk (0.2, 0.3).

E=Effectiveness of contraception in reducing fecundability (0.90, 0.95, 0.98, 0.99).

N=Period of exposure to risk, in months (12, 24, 36, 48, 60, 120).

D=Average duration of pregnancy at abortion plus postabortal infecundity (3 months).

^aSource: Tietze, C. The problem of repeat abortions, Family Planning Perspectives, 1974, 6, 148-150.

Appendix B

Traditional Sex-Determined Role Standards Scale

Directions: This is a questionnaire to find out what opinions people have about certain events. Each item consists of a pair of alternatives lettered A or B. Please select one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief: obviously there are no right or wrong answers.

Please answer these items carefully but do not spend too much time on any one item. Be sure to find an answer to every choice. Circle the A or B of the item which you choose as the statement more true. In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. A. A son should have use of the family car more often than a daughter.
B. A son and daughter should have the same car privileges.
2. A. In an emergency, women and children should be evacuated first.
B. Children should be first; men and women should follow.
3. A. Girls should have stricter hours than boys in a family.
B. The boys and girls should have the same curfew.
4. A. A man and woman should share expenses on a date if they both have income.
B. The man should pay.
5. A. "Dirty" stories should not be told in a woman's presence.
B. They should not be told at all, or they should be told regardless of the sex of those present.
6. A. I approve of a woman taking the aggressive role during sexual intercourse.
B. The man should always take the aggressive role.
7. A. I approve of a woman providing the financial support for the family, while the husband does the household tasks.
B. The husband should provide the money; the wife should do the housework.

8. A. Women should be given special courtesies not given to men.
B. Women should be given no more courtesies than men.
9. A. Men should not have their hair styled or dyed, or wear make-up to cover blemishes.
B. Men should have the same right to express concern over their appearance as women do.
10. A. Children should be reared with traditional sex-role stereotypes in mind.
B. Child rearing should proceed without regard for traditional sex-role stereotypes.
11. A. As long as there is a draft, both men and women should be included in it.
B. Women should not be expected to serve in the military.
12. A. A man who is really a man would not cry over a movie.
B. I approve of crying as an emotional outlet for both sexes.
13. A. Women, as well as men, should be found in top political offices.
B. Only men should be found in top political offices.
14. A. The husband's commitments should be given more weight than the wife's commitments when making important decisions.
B. The commitments of husband and wife should be given equal weight.
15. A. In a job situation, if a man has a woman superior, he need not react to her as he would to a male superior.
B. He should respond to a superior on the basis of rank, not sex.
16. A. I approve of a woman calling a man she is interested in.
B. A woman should wait for the man to call.
17. A. A man and woman should take turns driving on dates.
B. Even though both have access to a car, the man should always drive.
18. A. I approve of a woman taking the first step to start a relationship with a man.
B. The man should be the one to initiate the relationship.
19. A. Women should have the same opportunities for promotion as men if they are as qualified.
B. Men should be preferred for promotion because women quit more often, due to marriage or pregnancy.

Le présent questionnaire vise à découvrir les opinions qu'ont les gens par rapport à certains événements. Chaque article comprend deux possibilités, A ou B. Veuillez choisir l'énoncé (seulement un) que vous croyez correspondre le plus à votre cas personnel. Assurez-vous de choisir celui qui correspond à ce que vous croyez réellement être vrai plutôt que celui qui, selon vous, devrait être choisi ou que vous aimeriez être vrai. C'est une mesure d'opinion personnelle: Évidemment il n'y a aucune réponse bonne ni mauvaise.

Veuillez choisir votre énoncé soigneusement, mais sans prendre trop de temps; choisissez toujours un énoncé et encerclez la lettre A ou B de l'énoncé que vous estimez comme étant le plus véridique. Il peut arriver que les deux énoncés ou aucun d'eux ne vous semble vrai. Dans ce cas, choisissez celui qui correspond le plus fortement à ce que vous pensez être le plus véridique en ce qui vous concerne. Essayez aussi de répondre à chaque énoncé indépendamment sans vous laisser influencer par vos choix antérieurs.

1. A. Le fils devrait se servir de la voiture de la famille plus souvent que la fille.
B. Le fils et la fille devraient avoir les mêmes privilèges relativement à l'utilisation de la voiture.
2. A. En cas d'urgence, les femmes et les enfants devraient être évacués d'abord.
B. Les enfants devraient être évacués en premier; les hommes et les femmes devraient suivre.
3. A. On devrait fixer aux filles des heures plus strictes qu'aux garçons pour rentrer à la maison.
B. Les garçons et les filles devraient avoir les mêmes heures.
4. A. L'homme et la femme devraient partager les dépenses lors d'une sortie s'ils ont tous les deux un revenu.
B. L'homme devrait payer les dépenses.
5. A. On ne devrait pas raconter d'histoires sales en présence des femmes.
B. On ne devrait pas raconter du tout d'histoires sales ou elles devraient être racontées peu importe le sexe des personnes présentes.
6. A. J'approuve de la femme qui joue le rôle actif dans la relation sexuelle.
B. L'homme devrait toujours jouer le rôle actif.

7. A. J'approuve d'une femme soutenant financièrement la famille, alors que le mari s'occupe des tâches ménagères.
B. Le mari devrait fournir l'argent et la femme faire les travaux ménagers.
8. A. On devrait accorder des politesses spéciales aux femmes.
B. On ne devrait pas accorder plus de politesses aux femmes qu'aux hommes.
9. A. Les hommes ne devraient pas se faire faire de mise en plis, ni se teindre les cheveux, ni se maquiller pour cacher leurs imperfections.
B. Les hommes devraient avoir le même droit de se soucier de leur apparence que les femmes.
10. A. On devrait élever les enfants en gardant en tête les clichés traditionnels quant aux rôles qu'on attribue à l'homme ou à la femme.
B. On devrait élever les enfants sans faire cas des clichés traditionnels quant aux rôles qu'on attribue à l'homme ou à la femme.
11. A. Quand il y a une conscription, on devrait faire appel aux hommes et aux femmes.
B. On ne devrait pas compter sur les femmes pour faire partie de l'armée.
12. A. Un homme qui est vraiment un homme ne pleurerait pas en voyant un film.
B. J'approuve des larmes comme décharge émotive pour les deux sexes.
13. A. Les femmes aussi bien que les hommes devraient remplir des fonctions politiques supérieures.
B. Seuls les hommes devraient remplir des fonctions politiques supérieures.
14. A. On devrait accorder plus de poids aux obligations du mari qu'aux obligations de la femme lors de la prise de décisions importantes.
B. Les obligations de l'homme et de la femme devraient avoir un poids égal.
15. A. Dans un emploi, si un homme a une femme comme supérieur, il n'est pas nécessaire qu'il réagisse envers elle comme il le ferait envers un supérieur masculin.
B. Il devrait agir avec son supérieur en se fondant sur le rang, non sur le sexe.
16. A. J'approuve de la femme appelant un homme qui l'intéresse.
B. La femme devrait attendre que l'homme l'appelle.
17. A. Un homme et une femme devraient conduire la voiture chacun tour lors des sorties.
B. Même si tous les deux peuvent conduire la voiture, l'homme devrait toujours être le chauffeur.

18. A. J'approuve d'une femme faisant les premiers pas pour entamer une relation avec un homme.
B. L'homme devrait être le seul à prendre l'initiative.
19. A. Les femmes devraient avoir les mêmes possibilités d'accéder à des promotions que les hommes si elles sont aussi compétentes.
B. On devrait accorder la préférence aux hommes pour les promotions parce que les femmes quittent plus souvent leur emploi pour se marier ou avoir des enfants.

Appendix C

Attitude Toward Sex in General Scale

Directions: The following statements are meant to explore some of your feelings and attitudes toward sex in general. Read each item carefully and circle the corresponding number of the option that best expresses your feelings about the statement. For each item, use the following code.

- | 1. AGREE
STRONGLY | 2. AGREE | 3. UNCERTAIN | 4. DISAGREE | 5. DISAGREE
STRONGLY | | | | | |
|--|----------|--------------|-------------|-------------------------|---|---|---|---|---|
| 1. Too much is made of sex these days when it really isn't all that important. | | | | | 1 | 2 | 3 | 4 | 5 |
| 2. Sexual relationships should be experienced only in marriage where they properly belong. | | | | | 1 | 2 | 3 | 4 | 5 |
| 3. There is no good reason why matters of sex should not be discussed in public. | | | | | 1 | 2 | 3 | 4 | 5 |
| 4. What some people describe as pornographic literature or pictures can actually be helpful to develop a better sexual response. | | | | | 1 | 2 | 3 | 4 | 5 |
| 5. People who use a variety of positions during sexual relations are disgusting or sick. | | | | | 1 | 2 | 3 | 4 | 5 |
| 6. It is not necessarily indecent and against human nature for men to have sex with men and women with women. | | | | | 1 | 2 | 3 | 4 | 5 |
| 7. Sex is for having children and not for fun. | | | | | 1 | 2 | 3 | 4 | 5 |
| 8. The idea that some people enjoy sex in the absence of real love is quite acceptable. | | | | | 1 | 2 | 3 | 4 | 5 |
| 9. Women should ordinarily not make the first move in sexual relations with their partner. | | | | | 1 | 2 | 3 | 4 | 5 |
| 10. It's not as important for the woman to get sexual satisfaction as it is for the man. | | | | | 1 | 2 | 3 | 4 | 5 |
| 11. Most men just seek to satisfy themselves sexually at the expense of their partners. | | | | | 1 | 2 | 3 | 4 | 5 |
| 12. One indication of general happiness in marriage is having intercourse often. | | | | | 1 | 2 | 3 | 4 | 5 |

13. A girl need not be a virgin at the time of marriage to be a good wife. 1 2 3 4 5
14. Sex should be enjoyed, not just endured. 1 2 3 4 5
15. Marriage is primarily for the formation, protection and rearing of a family, and sex should be put second to this goal. 1 2 3 4 5

Instructions: Les énoncés qui suivent ont pour objet d'explorer certaines de vos idées et de vos attitudes face au sexe en général. Lisez chacun d'eux attentivement et encerclez le chiffre correspondant à ce qui exprime le mieux votre idée. Pour chaque énoncé, utilisez le code suivant.

1. FORTEMENT D'ACCORD 2. D'ACCORD 3. INCERTAIN(E) 4. EN DESACCORD
5. FORTEMENT EN DESACCORD
1. On accorde vraiment trop d'importance au sexe de nos jours 1 2 3 4 5
alors qu'en réalité ce n'est pas si important.
 2. On ne devrait avoir des relations sexuelles que dans le 1 2 3 4 5
mariage, car c'est là qu'est leur place.
 3. Il n'y a aucune bonne raison pour laquelle les questions 1 2 3 4 5
de sexe ne devraient pas être traitées en public.
 4. Ce que certaines personnes décrivent comme étant des 1 2 3 4 5
écrits ou des images pornographiques peut vraiment servir
à développer une meilleure réaction sexuelle.
 5. Les gens qui utilisent une variété de positions durant 1 2 3 4 5
les relations sexuelles sont dégoûtants ou malades.
 6. Ce n'est pas nécessairement indécent et contre la nature 1 2 3 4 5
humaine qu'un homme ait du sexe avec un homme et une femme
avec une femme.
 7. Le sexe a pour objet de faire des enfants et non d'avoir 1 2 3 4 5
du plaisir.
 8. L'idée que certaines personnes éprouvent du plaisir dans 1 2 3 4 5
des relations sexuelles sans amour réel est tout à fait
acceptable.
 9. La femme ne devrait pas ordinairement faire le premier 1 2 3 4 5
pas dans la relation sexuelle avec son partenaire.
 10. Ce n'est pas aussi important pour la femme que pour l'homme 2 3 4 5
de retirer une satisfaction sexuelle.

11. La plupart des hommes cherchent simplement à se satisfaire eux-mêmes sexuellement aux dépens de leur partenaire. 1 2 3 4 5
12. Le fait d'avoir souvent des relations sexuelles est généralement l'indice d'un mariage heureux. 1 2 3 4 5
13. Une fille n'a pas besoin d'être vierge au moment du mariage pour faire une bonne épouse. 1 2 3 4 5
14. On devrait trouver du plaisir dans les relations sexuelles et non les supporter tout simplement. 1 2 3 4 5
15. Le mariage a premièrement pour objet de former, de protéger et d'élever une famille et le sexe devrait être mis au second rang. 1 2 3 4 5

Appendix D

Premarital Contraceptive Attitude Instrument

Directions: The following statements are meant to explore some of your feelings and attitudes toward contraception in general. Read each item carefully and circle the corresponding number of the option that best expresses your feelings about the statement. For each item, use the following code.

- | 1. AGREE
STRONGLY | 2. AGREE | 3. UNCERTAIN | DISAGREE | 5. DISAGREE
STRONGLY | | | | | |
|--|----------|--------------|----------|-------------------------|---|---|---|---|---|
| 1. It is important for me to plan ahead of time for contraception in the event a relationship leads to sexual intercourse. | | | | | 1 | 2 | 3 | 4 | 5 |
| 2. The use of contraceptives outside of marriage cannot be justified. | | | | | 1 | 2 | 3 | 4 | 5 |
| 3. The use of contraception should be an accepted practice for non-marital sexual relations. | | | | | 1 | 2 | 3 | 4 | 5 |
| 4. Abstinence from premarital intercourse is preferable to artificial methods of contraception. | | | | | 1 | 2 | 3 | 4 | 5 |
| 5. Any form of contraception which will aid in the achievement of a fuller sexual relationship should be used and encouraged. | | | | | 1 | 2 | 3 | 4 | 5 |
| 6. Contraception is just too much trouble to bother with in non-marital relations. | | | | | 1 | 2 | 3 | 4 | 5 |
| 7. The risks of using artificial methods of contraception are worth the benefits they provide. | | | | | 1 | 2 | 3 | 4 | 5 |
| 8. The use of contraception distracts from the quality of a relationship. | | | | | 1 | 2 | 3 | 4 | 5 |
| 9. There is nothing wrong religiously or morally with the use of contraception. | | | | | 1 | 2 | 3 | 4 | 5 |
| 10. The use of any contraceptive that interferes with natural body functions is unacceptable. | | | | | 1 | 2 | 3 | 4 | 5 |
| 11. I consider learning how to use and knowing where to obtain methods of contraception an important part of responsible sexual behaviour. | | | | | 1 | 2 | 3 | 4 | 5 |

12. How anyone not married can use contraceptives is beyond me. 1 2 3 4 5
13. Effective contraception is essential to achieving sexual freedom. 1 2 3 4 5
14. I feel that it would be wrong for me to make plans ahead of time to use a contraceptive. 1 2 3 4 5
15. Anyway you look at it, it is right to use some form of contraception in non-marital sexual relations. 1 2 3 4 5
16. The use of contraception makes sexual intercourse seem dirty. 1 2 3 4 5
17. The results from using contraception are reliable. 1 2 3 4 5
18. I would rather risk pregnancy than use an artificial method of contraception. 1 2 3 4 5
19. Using a contraceptive to prevent unwanted pregnancy is a good thing to do. 1 2 3 4 5
20. Physical and psychological dangers would keep me from using any form of artificial contraception. 1 2 3 4 5
21. Contraception is a positive aspect of sexual relations. 1 2 3 4 5
22. I would reject the use of contraception on the basis that it disrupts the spontaneity of sexual behaviour. 1 2 3 4 5
23. I would feel guilty going into a drugstore and buying contraceptives. 1 2 3 4 5
24. I would not make prior plans for using contraceptives because that would mean I was planning on having intercourse. 1 2 3 4 5
25. I believe all means of contraception should be available to anyone who wants them. 1 2 3 4 5

Instructions: Les énoncés qui suivent ont pour objet d'explorer certaines de vos idées et de vos attitudes face au contraception en général. Lisez à la chacun d'eux attentivement et encerclez le chiffre correspondant à ce qui exprime le mieux votre idée. Pour chaque énoncé, utilisez le code suivant.

1. FORTEMENT D'ACCORD 2. D'ACCORD 3. INCERTAIN(E) 4. EN DESACCORD
5. FORTEMENT EN DESACCORD

- | | | | | | |
|--|---|---|---|---|---|
| 1. Il est important pour moi de planifier d'avance la contraception au cas où j'aurais une relation sexuelle. | 1 | 2 | 3 | 4 | 5 |
| 2. L'utilisation de contraceptifs en dehors du mariage ne peut pas être justifiée. | 1 | 2 | 3 | 4 | 5 |
| 3. On devrait accepter l'usage de contraceptifs pour les relations sexuelles en dehors du mariage. | 1 | 2 | 3 | 4 | 5 |
| 4. Il est préférable de s'abstenir d'avoir des relations sexuelles en dehors du mariage plutôt que d'utiliser des méthodes artificielles de contraception. | 1 | 2 | 3 | 4 | 5 |
| 5. Toute forme de contraception qui aide à réaliser une relation sexuelle plus pleine doit être utilisée et encouragée. | 1 | 2 | 3 | 4 | 5 |
| 6. Utiliser des moyens contraceptifs présente tout simplement trop d'ennuis pour s'en donner la peine dans des relations hors du mariage. | 1 | 2 | 3 | 4 | 5 |
| 7. Cela vaut la peine de prendre les risques que l'usage des méthodes artificielles de contraception peut amener pour les avantages qu'il procure. | 1 | 2 | 3 | 4 | 5 |
| 8. L'usage de contraceptifs brouille la qualité d'une relation sexuelle. | 1 | 2 | 3 | 4 | 5 |
| 9. Il n'y a rien de mauvais au point de vue religieux ou moral dans l'utilisation de contraceptifs. | 1 | 2 | 3 | 4 | 5 |
| 10. L'utilisation d'un contraceptif qui va à l'encontre des fonctions naturelles du corps n'est pas acceptable. | 1 | 2 | 3 | 4 | 5 |

11. Je considère qu'apprendre comment utiliser et savoir où obtenir des moyens de contraception constitue une partie importante du comportement sexuel responsable. 1 2 3 4 5
12. Qu'une personne non mariée puisse utiliser des contraceptifs me dépasse. 1 2 3 4 5
13. La contraception efficace est essentielle pour atteindre la liberté sexuelle. 1 2 3 4 5
14. J'estime qu'il ne serait pas bon pour moi de faire des plans en vue d'utiliser un moyen contraceptif. 1 2 3 4 5
15. Peu importe le point de vue, il est bon d'utiliser une forme de contraception dans les relations sexuelles en dehors du mariage. 1 2 3 4 5
16. L'utilisation de contraceptifs me fait paraître la relation sexuelle comme étant basse. 1 2 3 4 5
17. Les résultats de l'usage de contraceptifs sont sûrs. 1 2 3 4 5
18. Je risquerais plutôt de tomber enceinte que d'utiliser une méthode artificielle de contraception. 1 2 3 4 5
19. Il est bon d'utiliser un moyen contraceptif pour empêcher une grossesse non désirée. 1 2 3 4 5
20. Des dangers physiques et psychologiques m'empêcheraient d'utiliser une forme de contraception artificielle. 1 2 3 4 5
21. La contraception est un aspect positif des relations sexuelles. 1 2 3 4 5
22. Je rejetterais l'utilisation de moyens contraceptifs en me fondant sur le fait qu'ils nuisent à la spontanéité du comportement sexuel. 1 2 3 4 5
23. Je me sentirais coupable d'aller dans une pharmacie et d'acheter des contraceptifs. 1 2 3 4 5
24. Je ne ferais pas des plans d'avance pour utiliser des contraceptifs parce que cela voudrait dire que je songe à avoir une relation sexuelle. 1 2 3 4 5
25. Je crois que tous les moyens de contraception devraient être mis à la disposition de quiconque les veut. 1 2 3 4 5

Appendix E

Attitude Toward Abortion Scale

Directions: The following statements are meant to explore some of your feelings and attitudes toward abortion in general. Read each item carefully and circle the corresponding number of the option that best expresses your feelings about the statement. For each item, use the following code.

- | | 1. AGREE
STRONGLY | 2. AGREE | 3. UNCERTAIN | 4. DISAGREE | 5. DISAGREE
STRONGLY |
|--|----------------------|----------|--------------|-------------|-------------------------|
| 1. Laws against abortion should be more strongly enforced. | 1 | 2 | 3 | 4 | 5 |
| 2. Less rigid abortion laws would encourage freer sexual activity. | 1 | 2 | 3 | 4 | 5 |
| 3. Life begins at birth. | 1 | 2 | 3 | 4 | 5 |
| 4. It would be better to end a pregnancy than to have an unwanted child. | 1 | 2 | 3 | 4 | 5 |
| 5. After 3 months no pregnancy should be ended. | 1 | 2 | 3 | 4 | 5 |
| 6. If a single girl gets pregnant she should be given a legal abortion if she doesn't want the baby. | 1 | 2 | 3 | 4 | 5 |
| 7. If a married woman gets pregnant by somebody besides her husband she should be given a legal abortion to save her marriage. | 1 | 2 | 3 | 4 | 5 |
| 8. Abortion laws should be made more liberal. | 1 | 2 | 3 | 4 | 5 |
| 9. Qualified abortionists do a necessary service even though it is now illegal. | 1 | 2 | 3 | 4 | 5 |
| 10. All anti-abortion laws should be struck down. | 1 | 2 | 3 | 4 | 5 |
| 11. Ending a pregnancy for economic reasons reflects bad character. | 1 | 2 | 3 | 4 | 5 |
| 12. A pregnancy should be ended if it was the result of incest. | 1 | 2 | 3 | 4 | 5 |
| 13. Sex before marriage is part of growing up, and one should not be punished for doing it. | 1 | 2 | 3 | 4 | 5 |
| 14. If a country is really civilized, abortion wouldn't be restricted. | 1 | 2 | 3 | 4 | 5 |

15. If abortion laws were removed there would be less tension in male-female relationships. 1 2 3 4 5
16. The Catholic Church takes too strong a stand against abortion. 1 2 3 4 5
17. A pregnancy should be ended if the mother's physical well-being is at stake. 1 2 3 4 5
18. If a person had been reared properly, abortions wouldn't be needed. 1 2 3 4 5
19. The lower classes get abortions much more than the middle or upper class people. 1 2 3 4 5
20. Abortion laws are too liberal now. 1 2 3 4 5
21. If a friend of mine got ~~an~~ illegal abortion, I am sure her reasons were good enough. 1 2 3 4 5
22. The only result of ending a pregnancy early would be frustration. 1 2 3 4 5
23. No human has the authority to decide on the ending of a pregnancy. 1 2 3 4 5
24. Only a crazy person would seek an illegal abortion. 1 2 3 4 5
25. If abortion laws were lightened, the hospitals would be flooded with people wanting abortions. 1 2 3 4 5
26. Lightened abortion laws show moral decay in the society. 1 2 3 4 5
27. A pregnancy should be ended if it is likely that the baby will be deformed. 1 2 3 4 5
28. A pregnancy should be ended if the mother doesn't want the baby because she can't afford it. 1 2 3 4 5

Instructions: Les énoncés qui suivent ont pour objet d'explorer certaines de vos idées et de vos attitudes face à l'avortement en général. Lisez chacun d'eux attentivement et encerclez le chiffre correspondant à ce qui exprime le mieux votre idée. Pour chaque énoncé, utilisez le code suivant.

1. FORTEMENT D'ACCORD 2. D'ACCORD 3. INCERTAIN(E) 4. EN DESACCORD
5. FORTEMENT EN DESACCORD

- | | | | | | |
|---|---|---|---|---|---|
| 1. Les lois contre l'avortement devraient être mises en vigueur plus strictement. | 1 | 2 | 3 | 4 | 5 |
| 2. Des lois moins rigides sur l'avortement encourageraient une activité sexuelle plus libre. | 1 | 2 | 3 | 4 | 5 |
| 3. La vie commence à la naissance. | 1 | 2 | 3 | 4 | 5 |
| 4. Il serait préférable de mettre fin à une grossesse plutôt que d'avoir un enfant non désiré. | 1 | 2 | 3 | 4 | 5 |
| 5. Après trois mois, on ne devrait mettre fin à aucune grossesse. | 1 | 2 | 3 | 4 | 5 |
| 6. Si une fille célibataire tombe enceinte, on devrait lui permettre de se faire légalement avorter si elle ne désire pas l'enfant. | 1 | 2 | 3 | 4 | 5 |
| 7. Si une femme mariée tombe enceinte de quelqu'un d'autre que son mari, on devrait lui permettre de se faire légalement avorter pour sauver son mariage. | 1 | 2 | 3 | 4 | 5 |
| 8. Les lois sur l'avortement devraient être plus libérales. | 1 | 2 | 3 | 4 | 5 |
| 9. Les avorteurs qualifiés rendent un service nécessaire même si c'est illégal à l'heure actuelle. | 1 | 2 | 3 | 4 | 5 |
| 10. Toutes les lois contre l'avortement devraient être abolies. | 1 | 2 | 3 | 4 | 5 |
| 11. Mettre fin à une grossesse pour des raisons économiques est le reflet d'une personnalité immorale. | 1 | 2 | 3 | 4 | 5 |
| 12. On devrait mettre fin à une grossesse si elle est le résultat de l'inceste. | 1 | 2 | 3 | 4 | 5 |

LEAF 108 OMITTED IN PAGE NUMBERING.

13. Les relations sexuelles avant le mariage font partie de la croissance et on ne devrait pas punir quelqu'un pour cela. 1 2 3 4 5
14. Si un pays est vraiment civilisé, il ne devrait pas mettre de restrictions à l'avortement. 1 2 3 4 5
15. Si les lois contre l'avortement étaient supprimées, il y aurait moins de tension dans les relations entre hommes et femmes. 1 2 3 4 5
16. L'église catholique prend une position trop sévère contre l'avortement. 1 2 3 4 5
17. On devrait mettre fin à la grossesse si la santé physique de la mère est en danger. 1 2 3 4 5
18. Si une personne avait été élevée d'une façon appropriée, l'avortement ne serait pas nécessaire. 1 2 3 4 5
19. Les gens de la classe inférieure ont beaucoup plus recours à l'avortement que les gens de la classe moyenne ou supérieure. 1 2 3 4 5
20. Les lois sur l'avortement sont trop libérales à l'heure actuelle. 1 2 3 4 5
21. Si une de mes amies avait subi un avortement illégal, je suis certain(e) que ses raisons seraient suffisamment bonnes. 1 2 3 4 5
22. Le seul résultat atteint en mettant prématurément fin à une grossesse serait la frustration et la culpabilité. 1 2 3 4 5
23. Aucun humain n'est autorisé à décider de mettre fin à une grossesse. 1 2 3 4 5
24. Seule une personne folle chercherait un avortement illégal. 1 2 3 4 5
25. Si les lois sur l'avortement étaient allégées, les hôpitaux seraient bondés de gens désirant un avortement. 1 2 3 4 5
26. Les lois allégées sur l'avortement démontrent le dépérissement de la morale de la société. 1 2 3 4 5
27. On devrait mettre fin à une grossesse s'il y a des chances que l'enfant soit déformé. 1 2 3 4 5
28. On devrait mettre fin à une grossesse si la mère ne désire pas l'enfant parce qu'elle ne peut pas financièrement se permettre d'avoir un bébé. 1 2 3 4 5

Appendix F

Differential Personality Inventory

Directions: Answer each statement by circling either "T" for true or "F" for false.

- | | | |
|---|---|---|
| 1. I have a good night's sleep just about every night. | T | F |
| 2. I do not share my ideas with others. | T | F |
| 3. I never seem to be really happy. | T | F |
| 4. I cannot remember the meanings of many everyday words. | T | F |
| 5. Everything has changed so that nothing seems the same as before. | T | F |
| 6. People don't look after their health enough. | T | F |
| 7. My heart does not bother me. | T | F |
| 8. I almost always think things over before I take action. | T | F |
| 9. Few things that happen to me have a strong effect on my mind. | T | F |
| 10. When I have to do something, I usually get it done on time. | T | F |
| 11. Little things scare me more than they do most people. | T | F |
| 12. I never hear unknown voices warning me of danger. | T | F |
| 13. I have no more faults than most people. | T | F |
| 14. I get short of breath easily. | T | F |
| 15. My life was saved due to a heart operation. | T | F |
| 16. Whenever I am worried about something, I get a headache. | T | F |
| 17. I have not noticed anybody talking about me. | T | F |
| 18. I am happy in my present line of work. | T | F |
| 19. I can easily find my way around when I am left alone. | T | F |
| 20. People I should know never seem like strangers to me. | T | F |

- 21. I don't think germs are much of a threat at the present time. T F
- 22. When I get pains, I can't tell other people what they are like. T F
- 23. I usually do anything I feel like doing. T F
- 24. The way I feel depends a great deal on how the people around me feel. T F
- 25. I often lose things such as pencils and keys. T F
- 26. I do not panic more quickly than most people. T F
- 27. I see bright pictures and colours in my head, even when I don't want to. T F
- 28. I do not deserve kindness from others. T F
- 29. My eyes usually don't bother me when I read a lot. T F
- 30. Doctors know more now than they did 100 years ago. T F
- 31. I often wake up during the night. T F
- 32. I do not tell others how I feel about certain things. T F
- 33. I sometimes become saddened and think about killing myself. T F
- 34. I cannot remember how to do things which used to be easy for me. T F
- 35. Sometimes my surroundings appear to change so that I am in a strange place. T F
- 36. Public health is probably the biggest problem in the world today. T F
- 37. I do not have anything wrong with my body. T F
- 38. I always weigh any risks that I may have to take. T F
- 39. Little changes in the weather do not affect my mood. T F
- 40. When I have letters to mail, I very seldom forget to mail them. T F
- 41. My heart jumps and seems to stop when I am surprised. T F
- 42. My thoughts never seem so real that I think someone was talking to me. T F
- 43. I think my parents have no reason to be ashamed of me. T F

- | | | |
|---|---|---|
| 44. I sometimes have pains in my chest. | T | F |
| 45. I studied East African languages in school. | T | F |
| 46. I seldom get a "splitting headache". | T | F |
| 47. What people might be thinking about me does not worry me. | T | F |
| 48. I usually enjoy starting a new activity. | T | F |
| 49. I hardly ever lose my balance. | T | F |
| 50. Familiar things never seem "foggy" or far away to me. | T | F |
| 51. Rarely, if ever, do I read health and medical magazines. | T | F |
| 52. I have coughs that stay for a long time. | T | F |
| 53. If I'm asked a question, I generally give the first answer that comes into my head. | T | F |
| 54. My life is full of ups and downs. | T | F |
| 55. Even when I try, I sometimes seem to be unable to get to appointments on time. | T | F |
| 56. I never become so scared that I feel like running away. | T | F |
| 57. I hear voices talking about things that are too terrible to repeat. | T | F |
| 58. I am not very kind. | T | F |
| 59. My feet are usually warm enough. | T | F |
| 60. I am able to play chess blindfolded. | T | F |
| 61. I fall asleep very easily. | T | F |
| 62. I feel uncomfortable when I don't know what is going on behind my back. | T | F |
| 63. I live a dull life. | T | F |
| 64. I have trouble following directions even when they are carefully explained to me. | T | F |
| 65. My daydreams are sometimes so real to me that I can't stop them even when I try. | T | F |
- 2

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|-----|---|---|---|
| 66. | I like to have X-rays taken in case something is wrong which wouldn't show up in a regular examination. | T | F |
| 67. | I believe my physical health is good. | T | F |
| 68. | I do not mind doing one thing for a long period of time. | T | F |
| 69. | The way I feel about people does not change very much. | T | F |
| 70. | I am usually able to keep my mind on one thing at a time. | T | F |
| 71. | I often feel afraid of something that doesn't really matter to me at all. | T | F |
| 72. | My brain is not able to pick up thought waves out of the air. | T | F |
| 73. | I am an interesting person to talk with. | T | F |
| 74. | I often have pains that are so bad that I must go to bed. | T | F |
| 75. | I eat more often than once a day. | T | F |
| 76. | I often get headaches upon completing a day's work. | T | F |
| 77. | I seldom have the feeling that someone is trying to get the best of me. | T | F |
| 78. | Life is very interesting to me. | T | F |
| 79. | I can keep my mind on a radio or TV program long enough to understand what is happening. | T | F |
| 80. | I never have the feeling inside me that everything has changed. | T | F |
| 81. | I think people who don't worry about their health are a lot better off than those who do. | T | F |
| 82. | My stomach does not digest all the food that it should. | T | F |
| 83. | I usually do things in a hurry. | T | F |
| 84. | My surroundings can easily make me happy or sad. | T | F |
| 85. | It is hard for me to follow a schedule, even when I try. | T | F |
| 86. | I am able to remain calm even in unfamiliar places. | T | F |
| 87. | A special voice follows me everywhere I go. | T | F |
| 88. | I will never be suited for anything but the lowest and most simple sort of jobs. | T | F |

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|--|---|---|
| 89. I seldom have indigestion. | T | F |
| 90. I could talk before I went to school. | T | F |
| 91. I often have trouble sleeping because there is something on my mind. | T | F |
| 92. When I am around others, I often feel they are trying to keep me out of their group. | T | F |
| 93. I am depressed most of the time. | T | F |
| 94. I used to be able to think very clearly, but not any more. | T | F |
| 95. Even when I think that I know someone, I become unsure when I hear them speak. | T | F |
| 96. I am always on the lookout for symptoms which may indicate a serious illness. | T | F |
| 97. I don't think there is anything wrong with my health. | T | F |
| 98. Rarely, if ever, do I do foolish things without thinking. | T | F |
| 99. I am not excitable. | T | F |
| 100. I very seldom forget anything when I am packing for a trip. | T | F |
| 101. My own thoughts terrify me so much sometimes that I begin to feel faint. | T | F |
| 102. Faces of people I used to know never appear before me. | T | F |
| 103. I am the sort of person who can be depended upon. | T | F |
| 104. My eyes are often red and inflamed. | T | F |
| 105. Running usually tires me out more than walking. | T | F |
| 106. I hardly ever have pains in my head. | T | F |
| 107. I have several friends whom I can really trust. | T | F |
| 108. Each day has some event which holds my interest. | T | F |
| 109. I don't feel particularly clumsy these days. | T | F |
| 110. I never feel that I have been pushed outside the real world. | T | F |
| 111. I do not often visit a doctor. | T | F |

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|------|---|---|---|
| 112. | I always have some sort of sickness. | T | F |
| 113. | I may suddenly just get up and do something with no warning or reason. | T | F |
| 114. | I often change from feeling wonderful one moment to feeling terrible the next. | T | F |
| 115. | Many times I have forgotten what I was going to say. | T | F |
| 116. | I do not get upset with people who startle me. | T | F |
| 117. | Sometimes I hear voices which say things that only I can understand. | T | F |
| 118. | I long ago gave up hope of ever amounting to anything. | T | F |
| 119. | I do not suffer from backaches. | T | F |
| 120. | I can speak five or more languages. | T | F |
| 121. | I am not disturbed by loud noises when I am asleep. | T | F |
| 122. | Though people try to be nice to me, I often have the feeling they do not like me. | T | F |
| 123. | My present situation seems quite hopeless. | T | F |
| 124. | My mind sometimes goes blank when I am doing something so that I don't know how to go on. | T | F |
| 125. | I can hardly believe people still know me because I don't feel like the same person I used to be. | T | F |
| 126. | I try to keep my medicine chest full. | T | F |
| 127. | I seldom have pains in odd parts of my body. | T | F |
| 128. | I would not enjoy driving in a fast car. | T | F |
| 129. | People usually know how I will react to things. | T | F |
| 130. | When I start to do something, I usually keep at it until it's finished. | T | F |
| 131. | Even when I know something cannot hurt me, I sometimes feel afraid. | T | F |
| 132. | I have never had visions about events which will take place in the future. | T | F |

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|--|---|---|
| 133. I am worthy of "the good things in life". | T | F |
| 134. If I don't get enough sleep, I get sick. | T | F |
| 135. I am unable to see anything at all with my right eye. | T | F |
| 136. I seldom have to stop what I am doing because of a headache. | T | F |
| 137. People usually do nice things for me without hidden reasons. | T | F |
| 138. I am as happy as my friends. | T | F |
| 139. Most of the time I can understand what is going on. | T | F |
| 140. I never have the feeling that imaginary things are happening to me. | T | F |
| 141. I do not pay much attention to my body waste matter. | T | F |
| 142. When I have an illness, it's never in one place. | T | F |
| 143. Many times I do things without thinking. | T | F |
| 144. A small event can change my outlook for the whole day. | T | F |
| 145. I often lose track of the time. | T | F |
| 146. I never become scared when I am being introduced to strangers. | T | F |
| 147. Many times I am surrounded by voices that seem to come from nowhere. | T | F |
| 148. My whole life has been a big mistake. | T | F |
| 149. I am usually able to eat any type of food without bad aftereffects. | T | F |
| 150. I weigh over 300 pounds. | T | F |
| 151. I must have silence to get to sleep. | T | F |
| 152. I spend hours thinking out just exactly what I will say in certain conversations. | T | F |
| 153. I often think that I have very little to look forward to. | T | F |
| 154. My mind seems unable to control my actions. | T | F |
| 155. At times I don't know whether a minute or an hour has gone by. | T | F |

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|------|--|---|---|
| 156. | I watch to see that my body is always working properly. | T | F |
| 157. | My bones give me no trouble. | T | F |
| 158. | I'm a very careful and thoughtful person. | T | F |
| 159. | I do not get bored one minute and excited about something the next. | T | F |
| 160. | I don't waste time when I work. | T | F |
| 161. | Although I try very hard, I cannot keep from acting scared. | T | F |
| 162. | People never disappear before my eyes. | T | F |
| 163. | I often have something to say that is worth listening to. | T | F |
| 164. | Many foods upset my stomach. | T | F |
| 165. | Some days are warmer than others. | T | F |
| 166. | My head often seems ready to burst wide open. | T | F |
| 167. | I am not afraid that anyone will steal my ideas. | T | F |
| 168. | I do not feel very sad at the present time. | T | F |
| 169. | When I talk with several people, I find it easy to keep track of what is being said. | T | F |
| 170. | Words still mean the same things to me now as they used to. | T | F |
| 171. | I seldom take vitamin pills. | T | F |
| 172. | I can never really locate my illness. | T | F |
| 173. | I often do something "just for the heck of it". | T | F |
| 174. | My feelings change more often than most people's. | T | F |
| 175. | I often call people I know quite well by the wrong names. | T | F |
| 176. | I never feel very upset or frightened by the end of a hard day. | T | F |
| 177. | I am sometimes able to hear voices that seem to come from the sky. | T | F |
| 178. | I feel that I should apologize for most of the things I have done. | T | F |

179. It's easy for me to keep physically healthy. T F
180. I talk to someone almost every day. T F
181. I usually sleep very soundly. T F
182. When people whisper, I feel they might be talking about me. T F
183. Others always seem to enjoy life more than I. T F
184. When I try to think about one thing for more than a few minutes, I become nervous. T F
185. I feel as though there is a pane of glass separating me from other people. T F
186. I only eat in places where I know it is safe for my health. T F
187. Rarely, if ever, has my body felt completely limp. T F
188. I do almost everything very carefully. T F
189. The way I feel stays about the same from day to day. T F
190. I very seldom lose things. T F
191. I become afraid when I must go anywhere alone. T F
192. I cannot hear thought waves of people around me. T F
193. I usually show good judgement about things. T F
194. Sometimes my legs feel so weak that I can't walk. T F
195. I cannot see the difference between red and blue. T F
196. I never have any trouble with bad headaches. T F
197. I don't mind talking about my background and personal life to my friends. T F
198. My future is bright. T F
199. I have the ability to concentrate without my mind wandering in strange ways. T F
200. I am not experiencing any unusual changes in the way things appear. T F
201. I pay little or no attention to when my bowels move. T F

202. I am almost always aware of pains in some part of my body. T F
203. I'm willing to do almost anything on the spur of the moment. T F
204. On some days nothing bothers me, but at other times I am very touchy. T F
205. When I am thinking about something, I frequently do things with my hands that I am not aware of. T F
206. I remain quite calm when things go wrong. T F
207. Sometimes my brain is full of coloured lights. T F
208. People are better off when I am not around. T F
209. I seldom catch colds. T F
210. I have no trouble counting from one to twenty. T F
211. I am unable to go back to sleep if I wake up too early in the morning. T F
212. I think a great deal about what people's actions really mean. T F
213. My days seem gloomy and dull. T F
214. When several things are happening at once, I cannot keep them separated in my mind. T F
215. When I close my eyes, I am sure that things will look different when I open them again. T F
216. I do my very best to stay away from germs. T F
217. The blood in my body circulates all right. T F
218. I like to take time to plan things. T F
219. It takes a great deal to change my mood from happy to sad. T F
220. When I have set a plan for my time, I do not have any trouble keeping to it. T F
221. I start to feel scared when I think about the things that worry me. T F
222. I never talk with people from other worlds. T F
223. When I do things, I usually do them quite well. T F

224. I often have an upset stomach. T F
225. I learned how to fix watches in Switzerland. T F
226. I often get headaches. T F
227. I hardly ever feel that people are finding fault with me. T F
228. I enjoy almost everything I do. T F
229. I am able to do easy arithmetic problems without making mistakes. T F
230. I don't feel as if I'm living in a dream world. T F
231. I worry very little about my health. T F
232. I often have infections in the strangest parts of my body. T F
233. I often do dangerous things without stopping to think about the results. T F
234. The way I feel about my life changes quite often. T F
235. I often forget to do things that I should do. T F
236. I never get so scared that I become physically ill. T F
237. I can hear a voice warn me when I do anything evil. T F
238. I am of no use to anyone. T F
239. My joints don't ache. T F
240. I could probably cook some food for myself if I needed to badly enough. T F

Instructions: Répondre à chaque énoncé en encerclant soit "V" pour vrai ou "F" pour faux.

- | | | |
|--|---|---|
| 1. En général, j'ai une bonne nuit de sommeil. | V | F |
| 2. Je ne partage pas mes idées avec d'autres. | V | F |
| 3. Je n'ai jamais l'impression d'être vraiment heureux(se). | V | F |
| 4. Je ne peux pas me rappeler la signification d'un grand nombre de mots courants. | V | F |
| 5. Tout a changé de sorte que rien ne me semble comme avant. | V | F |
| 6. Les gens ne se soucient pas assez de leur santé. | V | F |
| 7. Mon coeur ne me cause pas d'ennui. | V | F |
| 8. Je réfléchis presque toujours, avant de passer à l'action. | V | F |
| 9. Peu des choses qui m'arrivent influencent beaucoup mon humeur. | V | F |
| 10. Quand j'ai quelque chose à faire, je le fais habituellement à temps. | V | F |
| 11. Les petites choses m'effraient plus que la plupart des gens. | V | F |
| 12. Je n'entends jamais des voix inconnues m'avertissant de danger. | V | F |
| 13. Je n'ai pas plus de défauts que la plupart des gens. | V | F |
| 14. Je manque de souffle facilement. | V | F |
| 15. J'ai eu la vie sauve grâce à une opération cardiaque. | V | F |
| 16. Dès que je m'inquiète de quelque chose, j'ai un mal de tête. | V | F |
| 17. Je n'ai remarqué personne parlant de moi. | V | F |
| 18. Je suis heureux(se) dans mon genre de travail actuel. | V | F |
| 19. Je peux facilement me débrouiller quand je suis laissé(e) à moi-même. | V | F |

20. Les gens que je devrais connaître ne me semblent jamais des étrangers. V F
21. Je ne pense pas que les microbes soient une grande menace à l'heure actuelle. V F
22. Quand j'ai des douleurs, je ne peux pas dire aux autres ce que je ressens. V F
23. Je fais habituellement tout ce que j'ai envie de faire. V F
24. La façon dont je me sens dépend beaucoup de la façon dont les gens autour de moi se sentent. V F
25. Je perds souvent des choses comme des crayons et des clés. V F
26. Je ne suis pas pris(e) de panique plus facilement que la plupart des gens. V F
27. Je vois des images et des couleurs brillantes dans ma tête même quand je ne le veux pas. V F
28. Je ne mérite pas que les autres soient gentils avec moi. V F
29. Mes yeux ne me gênent pas habituellement quand je lis beaucoup. V F
30. Les médecins en connaissent plus maintenant qu'ils n'en connaissaient il y a cent ans. V F
31. Je me réveille souvent pendant la nuit. V F
32. Je ne dis pas aux autres ce que je ressens sur certaines choses. V F
33. Il m'arrive parfois de devenir triste et de penser à me suicider. V F
34. Je ne peux pas me rappeler comment faire des choses qui m'étaient autrefois faciles. V F
35. Parfois mon environnement semble changer, ce qui fait que je me sens dans un endroit étranger. V F
36. La santé publique est probablement le plus gros problème du monde actuel. V F
37. Il n'y a rien qui va mal avec mon corps. V F
38. Je pèse toujours les risques que je pourrais avoir à courir. V F
39. Les petits changements de la température n'affectent pas mon humeur. V F

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| 40. | Quand j'ai des lettres à mettre à la poste, j'oublie très rarement de les poster. | V | F |
| 41. | Mon coeur fait un bond et semble s'arrêter quand je suis surpris(e). | V | F |
| 42. | Mes pensées ne me semblent jamais réelles au point de me faire penser que quelqu'un était en train de me parler. | V | F |
| 43. | Je pense que mes parents n'ont aucune raison d'avoir honte de moi. | V | F |
| 44. | J'ai parfois des douleurs à la poitrine. | V | F |
| 45. | J'ai étudié les langues de l'Afrique de l'est à l'école. | V | F |
| 46. | Il m'arrive rarement d'avoir un mal de tête terrible. | V | F |
| 47. | Ce que les gens peuvent penser de moi ne m'inquiète pas. | V | F |
| 48. | J'aime habituellement commencer une nouvelle activité. | V | F |
| 49. | Je ne perds presque jamais mon équilibre. | V | F |
| 50. | Les choses familières ne me semblent jamais floues ou loin de moi. | V | F |
| 51. | Il m'arrive rarement, sinon jamais, de lire des revues de santé et de médecine. | V | F |
| 52. | J'ai des toux qui durent longtemps. | V | F |
| 53. | Si l'on me pose une question, jè donne généralement la première réponse qui me vient à l'esprit. | V | F |
| 54. | Ma vie est pleine de hauts et de bas. | V | F |
| 55. | Même quand j'essaie, je semble parfois être incapable d'arriver à un rendez-vous à l'heure. | V | F |
| 56. | Il ne m'arrive jamais d'être effrayé(e) au point d'avoir envie de me sauver. | V | F |
| 57. | J'entends des voix me parler des choses qui sont trop terribles pour être répétées. | V | F |
| 58. | Je ne suis pas très gentil(le). | V | F |
| 59. | Mes pieds sont habituellement assez chauds. | V | F |
| 60. | Je suis capable de jouer aux échecs les yeux bandés. | V | F |

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| 61. | Je m'endors très facilement. | V | F |
| 62. | Je ne me sens pas à l'aise quand je ne sais pas ce qui se passe derrière mon dos. | V | F |
| 63. | Je mène une vie ennuyeuse. | V | F |
| 64. | J'ai de la difficulté à suivre des directives même quand elles me sont expliquées soigneusement. | V | F |
| 65. | Mes rêves éveillés sont parfois tellement réels que je ne peux pas les arrêter même quand j'essaie de le faire. | V | F |
| 66. | J'aime subir des radiographies au cas où quelque chose n'irait pas bien et ne serait pas révélé lors d'un examen régulier. | V | F |
| 67. | Je crois que je suis en bonne santé physique. | V | F |
| 68. | Ça ne me dérange pas de faire quelque chose pendant une longue période de temps. | V | F |
| 69. | Les sentiments que j'éprouve pour les gens ne changent pas beaucoup. | V | F |
| 70. | Je suis habituellement capable de concentrer mon esprit sur une chose à la fois. | V | F |
| 71. | J'ai souvent peur de quelque chose qui ne m'importe vraiment pas du tout. | V | F |
| 72. | Mon cerveau n'est pas capable de saisir les ondes de pensées dans l'air. | V | F |
| 73. | Je suis une personne avec laquelle il est intéressant de converser. | V | F |
| 74. | J'ai souvent des douleurs si fortes que je dois me coucher. | V | F |
| 75. | Je mange plus souvent qu'une fois par jour. | V | F |
| 76. | J'ai souvent des maux de tête une fois ma journée de travail terminée. | V | F |
| 77. | Il m'arrive rarement d'avoir l'impression que quelqu'un essaie de profiter de moi. | V | F |
| 78. | Je trouve la vie très intéressante. | V | F |
| 79. | Je peux me concentrer sur une émission de radio ou de télévision assez longtemps pour comprendre ce qui s'y passe. | V | F |

80. Je n'ai jamais l'impression en dedans de moi que tout a changé. V F
81. Je pense que les gens qui ne s'inquiètent pas de leur santé sont mieux nantis que ceux qui s'en inquiètent. V F
82. Mon estomac ne digère pas toute la nourriture qu'il devrait. V F
83. Je fais habituellement les choses à la hâte. V F
84. Mon environnement peut facilement me rendre heureux(se) ou triste. V F
85. Il est difficile pour moi de suivre un horaire, même quand j'essaie. V F
86. Je suis capable de rester calme même dans des endroits qui ne me sont pas familiers. V F
87. Une voix spéciale me suit partout où je vais. V F
88. Je ne pourrai jamais faire que les travaux les plus bas et les plus simples. V F
89. J'ai rarement des indigestions. V F
90. Je pouvais parler avant d'aller à l'école. V F
91. J'ai souvent des difficultés à dormir parce qu'il y a quelque chose qui me tracasse. V F
92. Quand je suis avec d'autres, j'ai souvent l'impression qu'ils essaient de me tenir à l'écart. V F
93. Je suis déprimé(e) la plupart du temps. V F
94. Avant, j'étais capable de penser très clairement, mais plus maintenant. V F
95. Même quand je pense connaître quelqu'un, j'en suis moins sûr(e) quand je l'entends parler. V F
96. Je suis toujours à l'affût de symptômes qui pourraient être le signe d'une maladie grave. V F
97. Je ne pense pas avoir de problèmes avec ma santé. V F
98. Il m'arrive rarement, sinon jamais, de faire des choses stupides sans réfléchir. V F
99. Je ne suis pas excitable. V F

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| 100. | J'oublie très rarement quelque chose quand je fais mes valises pour un voyage. | V | F |
| 101. | Mes propres pensées me terrifient tellement parfois que je commence à m'évanouir. | V | F |
| 102. | Les visages des gens que je connaissais n'apparaissent jamais devant moi. | V | F |
| 103. | Je suis le genre de personne dont on peut dépendre. | V | F |
| 104. | Mes yeux sont souvent rouges et enflés. | V | F |
| 105. | Courir me fatigue habituellement plus que marcher. | V | F |
| 106. | Je n'ai presque jamais de douleurs à la tête. | V | T |
| 107. | J'ai plusieurs amis à qui je peux vraiment faire confiance. | V | F |
| 108. | Chaque jour amène un événement qui retient mon intérêt. | V | F |
| 109. | Je ne me sens pas particulièrement maladroit(e) ces jours-ci. | V | F |
| 110. | Je n'ai jamais l'impression qu'on m'a poussé à l'extérieur du monde réel. | V | F |
| 111. | Je ne rends pas souvent visite au médecin. | V | F |
| 112. | J'ai toujours une maladie quelconque. | V | F |
| 113. | Il peut m'arriver de me lever soudainement et de faire quelque chose sans avertissement ni raison. | V | F |
| 114. | Il m'arrive souvent de me sentir merveilleusement bien à un moment donné puis terriblement mal tout de suite après. | V | F |
| 115. | Il m'arrive très souvent d'oublier ce que j'allais dire. | V | F |
| 116. | Je ne me fâche pas avec les gens qui me font sursauter. | V | F |
| 117. | Il m'arrive parfois d'entendre des voix qui disent des choses que je suis seul(e) à pouvoir comprendre. | V | F |
| 118. | J'ai depuis longtemps abandonné tout espoir de parvenir à quelque chose. | V | F |
| 119. | Je ne souffre pas de douleurs de dos. | V | F |
| 120. | Je peux parler au moins cinq langues. | V | F |
| 121. | Les bruits forts ne me dérangent pas quand je dors. | V | F |

122. Bien que les gens essaient d'être gentils avec moi, j'ai souvent l'impression qu'ils ne m'aiment pas. V F
123. Ma situation actuelle semble tout à fait désespérée. V F
124. J'ai souvent un trou dans mon esprit quand je suis en train de faire quelque chose de sorte que je ne sais pas comment continuer. V F
125. Je peux à peine croire que les gens me connaissent encore parce que je n'ai pas l'impression d'être la même personne que j'étais. V F
126. J'essaie de garder mon cabinet de médecine plein. V F
127. J'ai rarement des douleurs dans des parties étranges de mon corps. V F
128. Je n'aimerais pas monter dans une voiture rapide. V F
129. Les gens savent habituellement quelles seront mes réactions. V F
130. Quand je commence à faire quelque chose, je continue tant que je n'ai pas fini. V F
131. Même si je sais que quelque chose ne peut pas me faire mal, j'ai parfois peur. V F
132. Je n'ai jamais eu de visions sur des événements qui peuvent survenir dans l'avenir. V F
133. Je mérite les bonnes choses de la vie. V F
134. Si je ne dors pas suffisamment, je tombe malade. V F
135. Je ne suis pas capable de voir quoique ce soit avec mon oeil droit. V F
136. Il m'arrive rarement d'avoir à cesser de faire quelque chose en cours parce que j'ai mal à la tête. V F
137. Les gens me font habituellement des gentilleses sans raisons cachées. V F
138. Je suis aussi heureux(se) que mes amis(es). V F
139. La plupart du temps, je peux comprendre ce qui se passe. V F
140. Je n'ai jamais l'impression que des choses imaginaires m'arrivent. V F
141. Je ne porte pas beaucoup d'attention aux déchets de mon corps. V F

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| 142. | Quand j'ai une maladie, ce n'est jamais à un endroit déterminé. | V | F |
| 143. | Il m'arrive souvent de faire des choses sans réfléchir. | V | F |
| 144. | Un petit évènement peut changer ma perspective de toute la journée. | V | F |
| 145. | Je perds souvent la notion du temps. | V | F |
| 146. | Je ne suis jamais effrayé(e) quand on me présente a des étrangers. | V | F |
| 147. | Il arrive très souvent que je sois entouré(e) de voix qui semblent venir de nulle part. | V | F |
| 148. | Toute ma vie a été une grosse erreur. | V | F |
| 149. | Je suis habituellement capable de manger n'importe quelle sorte d'aliments sans de mauvaises reactions. | V | F |
| 150. | Je pèse plus de 300 livres. | V | F |
| 151. | J'ai besoin de silence pour dormir. | V | F |
| 152. | Je passe des heures à penser à ce que je vais dire exactement dans certaines conversations. | V | F |
| 153. | Je pense souvent que je n'ai pas grand chose à attendre avec plaisir. | V | F |
| 154. | Mon esprit semble incapable de maîtriser mes actes. | V | F |
| 155. | Parfois, je ne sais pas si c'est une minute ou une heure qui vient de s'écouler. | V | F |
| 156. | Je vois à ce que mon corps fonctionne toujours bien. | V | F |
| 157. | Mes os ne me causent aucun trouble. | V | F |
| 158. | Je suis une personne très soigneuse et réfléchie. | V | F |
| 159. | Je ne passe pas de l'ennui à l'excitation facilement. | V | F |
| 160. | Je ne perds pas de temps quand je travaille. | V | F |
| 161. | Bien que je fasse beaucoup d'efforts, je ne peux pas m'empêcher d'être effrayé(e). | V | F |
| 162. | Les gens ne disparaissent jamais devant mes yeux. | V | F |

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| 163. | Il m'arrive souvent d'avoir à dire des choses qu'il vaut la peine d'écouter. | V | F |
| 164. | De nombreux aliments dérangent mon estomac. | V | F |
| 165. | Certains jours sont plus chauds que d'autres. | V | F |
| 166. | Ma tête semble souvent prête à éclater. | V | F |
| 167. | Je n'ai pas peur que quelqu'un me vole mes idées. | V | F |
| 168. | Je ne me sens pas très triste à l'heure actuelle. | V | F |
| 169. | Quand je parle avec plusieurs personnes, il m'est facile de suivre ce qui est dit. | V | F |
| 170. | Les mots ont la même signification pour moi maintenant que dans le passé. | V | F |
| 171. | Je prends rarement des vitamines en pilules. | V | F |
| 172. | Je ne peux jamais localiser vraiment ma maladie. | V | F |
| 173. | Il m'arrive souvent de faire quelque chose juste pour le plaisir de le faire. | V | F |
| 174. | Mes sentiments changent plus souvent que ceux de la plupart des gens. | V | F |
| 175. | J'appelle souvent des gens que je connais très bien par un mauvais nom. | V | F |
| 176. | Je ne me sens jamais bouleversé(e) ni effrayé(e) à la fin d'une dure journée. | V | F |
| 177. | Je suis parfois capable d'entendre des voix qui semblent venir du ciel. | V | F |
| 178. | Je pense que je devrais m'excuser pour la plupart des choses que j'ai faites. | V | F |
| 179. | C'est facile pour moi de me tenir physiquement en forme. | V | F |
| 180. | Je parle à quelqu'un presque tous les jours. | V | F |
| 181. | Je dors habituellement très profondément. | V | F |
| 182. | Quand les gens chuchotent, j'ai l'impression qu'ils pourraient parler de moi. | V | F |
| 183. | Les autres semblent toujours jouir de la vie plus que moi. | V | F |

184. Quand j'essaie de penser à une chose pendant plus de quelques minutes, je deviens nerveux(se). V F
185. Je me sens comme si une vitre me séparait des autres personnes. V F
186. Je mange seulement dans des endroits qui sont sains pour ma santé. V F
187. Rarement, sinon jamais, ai-je senti mon corps complètement mou. V F
188. Je fais presque tout très soigneusement. V F
189. La façon dont je me sens demeure à peu près la même de jour en jour. V F
190. Je perds rarement quelque chose. V F
191. Je deviens effrayé(e) quand je dois aller seul(e) quelque part. V F
192. Je ne peux pas entendre les ondes de pensée des gens autour de moi. V F
193. J'ai habituellement un bon jugement sur les choses. V F
194. Parfois mes jambes sont si faibles que je ne peux pas marcher. V F
195. Je ne peux pas voir la différence entre le rouge et le bleu. V F
196. Je n'ai jamais de problème avec des maux de tête terribles. V F
197. Cela ne me dérange pas de parler de mes antécédents et de ma vie privée à mes amis. V F
198. Mon avenir est brillant. V F
199. J'ai la capacité de me concentrer sans que mon esprit vagabonde de façons étranges. V F
200. Je n'expérimente aucun changement inhabituel dans la façon dont les choses semblent être. V F
201. Je ne porte pas beaucoup ou pas du tout attention aux mouvements de mes intestins. V F
202. Je suis presque toujours conscient(e) de douleurs dans une partie de mon corps. V F
203. Je suis d'accord pour faire presque n'importe quoi sur l'impulsion du moment. V F
204. Certains jours, rien ne me dérange, mais à d'autres moments, je suis très susceptible. V F

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| 205. | Quand je pense à quelque chose, il m'arrive souvent de faire des choses avec mes mains sans que je ne m'en rende compte. | V | F |
| 206. | Je demeure tout à fait calme quand les choses vont mal. | V | F |
| 207. | Parfois mon cerveau est plein de lumières colorées. | V | F |
| 208. | Les gens sont mieux quand je ne suis pas là. | V | F |
| 209. | J'attrape rarement le rhume. | V | F |
| 210. | Je n'ai pas de difficulté à compter de un à vingt. | V | F |
| 211. | Je ne suis pas capable de me rendormir si je me suis réveillé(e) trop tôt le matin. | V | F |
| 212. | Je pense beaucoup à la signification réelle des actions des gens. | V | F |
| 213. | Mes jours semblent sombres et ennuyants. | V | F |
| 214. | Quand plusieurs choses se produisent en même temps, je ne peux pas les séparer dans mon esprit. | V | F |
| 215. | Quand je ferme les yeux, je suis certain(e) que je verrai les choses différemment quand je les rouvrirai. | V | F |
| 216. | Je fais tout ce que je peux pour m'éloigner des microbes. | V | F |
| 217. | Le sang circule très bien dans mon corps. | V | F |
| 218. | J'aime prendre du temps pour planifier les choses. | V | F |
| 219. | Il m'en faut beaucoup pour changer mon humeur heureuse en humeur triste. | V | F |
| 220. | Quand je me suis déterminé un plan de travail, je n'ai pas de difficulté à m'y conformer. | V | F |
| 221. | Je commence à me sentir effrayé(e) quand je pense aux choses qui m'inquiètent. | V | F |
| 222. | Je ne parle jamais avec des gens d'autres mondes. | V | F |
| 223. | Quand je fais des choses, je les fais habituellement très bien. | V | F |
| 224. | J'ai souvent l'estomac dérangé. | V | F |
| 225. | J'ai appris comment réparer les montres en Suisse. | V | F |
| 226. | J'ai souvent des maux de tête. | V | F |

216. Je fais tout ce que je peux pour m'éloigner des microbes. V F
217. Le sang circule très bien dans mon corps. V F
218. J'aime prendre du temps pour planifier les choses. V F
219. Il m'en faut beaucoup pour changer mon humeur heureuse en humeur triste. V F
220. Quand je me suis déterminé un plan de travail, je n'ai pas de difficulté à m'y conformer. V F
221. Je commence à me sentir effrayé(e) quand je pense aux choses qui m'inquiètent. V F
222. Je ne parle jamais avec des gens d'autres mondes. V F
223. Quand je fais des choses, je les fais habituellement très bien. V F
224. J'ai souvent l'estomac dérangé. V F
225. J'ai appris comment réparer les montres en Suisse. V F
226. J'ai souvent des maux de tête. V F
227. Je ne pense pas que les gens aient beaucoup à redire à mon sujet. V F
228. Ce que je fais me plaît presque toujours. V F
229. Je suis capable de résoudre des problèmes d'arithmétique faciles sans faire d'erreurs. V F
230. Je ne me sens pas comme si je vivais dans un monde imaginaire. V F
231. Je m'inquiète très peu de ma santé. V F
232. J'ai souvent des infections dans les parties les plus étranges de mon corps. V F
233. Je fais souvent des choses dangereuses sans m'arrêter pour penser aux résultats. V F
234. Ma façon de voir ma vie change très souvent. V F
235. J'oublie souvent de faire les choses que je devrais faire. V F

236. Rien ne m'effraie tant que j'en tombe physiquement
malade. V F
237. Je peux entendre une voix m'avertir quand j'agis mal. V F
238. Je ne suis d'aucune utilité à personne. V F
239. Mes jointures ne me font pas souffrir. V F
240. Je pourrais probablement me faire à manger pour
moi-même si j'en avais réellement besoin. V F

Appendix G

Internal-External Scale and Mirels' Internal-External Scoring

Directions: This is a questionnaire to find out what opinions people have about certain events. Each item consists of a pair of alternatives lettered A or B. Please select one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief: obviously there are no right or wrong answers.

Please answer these items carefully but do not spend too much time on any one item. Be sure to find an answer to every choice. Circle the A or B of the item which you choose as the statement more true. In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. A. Children get into trouble because their parents punish them too much
B. The trouble with most children nowadays is that their parents are too easy with them.
2. A. Many of the unhappy things in people's lives are partly due to bad luck.
B. People's misfortunes result from the mistakes they make.
3. A. One of the major reasons why we have wars is because people don't take enough interest in politics.
B. There will always be wars, no matter how hard people try to prevent them.
4. A. In the long run, people get the respect they deserve in this world.
B. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
- * 5. A. The idea that teachers are unfair to students is nonsense.
B. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. A. Without the right breaks one cannot be an effective leader.
B. Capable people who fail to become leaders have not taken advantage of their opportunities.

8. A. Heredity plays the major role in determining one's personality.
B. It is one's experiences in life which determine what they're like.
9. A. I have often found that what is going to happen will happen.
B. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
- * 10. A. In the case of the well prepared student there is rarely if ever such a thing as an unfair exam.
B. Many exam questions tend to be so unrelated to course work that studying is really useless.
- * 11. A. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
B. Getting a good job depends mainly on being in the right place at the right time.
12. A. The average citizen can have an influence in government decisions.
B. This world is run by the few people in power, and there is not much the little guy can do about it.
13. A. When I make plans, I am almost certain that I can make them work.
B. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
14. A. There are certain people who are just no good.
B. There is some good in everybody.
- * 15. A. In my case, getting what I want has little or nothing to do with luck.
B. Many times we might just as well decide what to do by flipping a coin.
- * 16. A. Who gets to be the boss often depends upon who was lucky enough to be in the right place first.
B. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.
17. A. As far as world affairs are concerned, most of us are the victims of forces we can neither understand or control.
B. By taking an active part in political and social affairs the people can control world events.
- * 18. A. Most people don't realize the extent to which their lives are controlled by accidental happenings.
B. There is really no such thing as "luck".
19. A. One should always be willing to admit mistakes.
B. It is usually best to cover up one's mistakes.

20. A. It is hard to know whether or not a person really likes you.
B. How many friends you have depends upon how nice a person you are.
21. A. In the long run, the bad things that happen to us are balanced by the good ones.
B. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22. A. With enough effort we can wipe out political corruption.
B. It is difficult for people to have much control over the things politicians do in office.
- * 23. A. Sometimes I can't understand how teachers arrive at the grades they give.
B. There is a direct connection between how hard I study and the grades I get.
24. A. A good leader expects people to decide for themselves what they should do.
B. A good leader makes it clear to everybody what their jobs are.
- * 25. A. Many times I feel that I have little influence over the things that happen to me.
B. It is impossible for me to believe that chance or luck plays an important role in my life.
26. A. People are lonely because they don't try to be friendly.
B. There's not much use in trying hard to please people, if they like you, they like you.
27. A. There is too much emphasis on athletics in high school.
B. Team sports are an excellent way to build character.
- * 28. A. What happens to me is my own doing.
B. Sometimes I feel that I don't have enough control over the direction my life is taking.
29. A. Most of the time I can't understand why politicians behave the way they do.
B. In the long run the people are responsible for bad government on a national as well as local level.

Le présent questionnaire vise à découvrir les opinions qu'ont les gens par rapport à certains événements. Chaque article comprend deux possibilités, A ou B. Veuillez choisir l'énoncé (seulement un) que vous croyez correspondre le plus à votre cas personnel. Assurez-vous de choisir celui qui correspond à ce que vous croyez réellement être vrai plutôt que celui qui, selon vous, devrait être choisi ou que vous aimeriez être vrai. C'est une mesure d'opinion personnelle: Evidemment il n'y a aucune réponse bonne ni mauvaise.

Veuillez choisir votre énoncé soigneusement, mais sans prendre trop de temps; choisissez toujours un énoncé et encerclez la lettre A ou B de l'énoncé que vous estimez comme étant le plus véridique. Il peut arriver que les deux énoncés ou aucun d'eux ne vous semble vrai. Dans ce cas, choisissez celui qui correspond le plus fortement à ce que vous pensez être le plus véridique en ce qui vous concerne. Essayez aussi de répondre à chaque énoncé indépendamment sans vous laisser influencer par vos choix antérieurs.

1. A. Les enfants s'attirent des ennuis parce que leurs parents les punissent trop.
B. L'ennui avec la plupart des enfants de nos jours c'est que leurs parents ne sont pas assez sévères avec eux.
2. A. Bon nombre de choses malheureuses dans la vie des gens sont en partie dues à la malchance.
B. Les malheurs des gens découlent des erreurs qu'ils font.
3. A. Une des principales raisons pour lesquelles les guerres se produisent c'est que les gens ne s'intéressent pas assez à la politique.
B. Il y aura toujours des guerres, peu importe combien les gens s'efforcent de les empêcher.
4. A. Avec le temps, les gens finissent par obtenir le respect qu'ils méritent en ce monde.
B. Malheureusement, il arrive souvent que la valeur d'un individu ne soit pas reconnue malgré tous les efforts qu'il fait.
- * 5. A. L'idée que les professeurs sont injustes envers les étudiants est insensée.
B. La plupart des étudiants ne se rendent pas compte à quel point leurs notes sont influencées par le hasard.

6. A. Sans le bon coup de chance, on ne peut pas devenir un meneur efficace.
 B. Les personnes compétentes qui ne deviennent pas des meneurs n'ont pas profité des chances qui leur étaient offertes.
7. A. Peu importe les efforts que vous faites; certaines personnes ne vous aiment tout simplement pas.
 B. Les gens qui ne peuvent pas se faire aimer des autres savent pas comment s'entendre avec les autres.
8. A. L'hérédité est le facteur déterminant de la personnalité.
 B. Ce sont les expériences de la vie des gens qui déterminent ce qu'ils sont.
9. A. J'ai souvent constaté que ce qui doit arriver arrive effectivement.
 B. M'en remettre au destin n'a jamais eu pour moi un aussi bon résultat que de décider de mes actions.
- * 10. A. Pour un étudiant bien préparé il y a rarement, sinon jamais, un examen injuste.
 B. De nombreuses questions d'examen sont généralement si peu rattachées au cours qu'étudier est vraiment inutile.
- * 11. A. Réussir est une question de travail ardu, la chance n'a que peu ou rien à y voir.
 B. Obtenir un bon emploi dépend surtout du fait de se trouver au bon endroit au bon moment.
12. A. Le citoyen moyen peut avoir de l'influence sur les décisions gouvernementales.
 B. Notre monde est dirigé par les puissants et les petits n'y peuvent pas grand chose.
13. A. Quand je fais des plans, je suis presque certain de pouvoir les mener à bout.
 B. Il n'est pas toujours sage de faire des plans à l'avance parce que beaucoup de choses sont le résultat de chance ou malchance de toutes façons.
14. A. Certaines personnes sont tout simplement mauvaises.
 B. Il y a du bon dans toute personne.
- * 15. A. Dans mon cas, obtenir ce que j'en veux n'a que peu ou rien à voir avec la chance.
 B. On pourrait souvent aussi bien prendre une décision en jouant à pile ou face.
- * 16. A. Le fait de devenir le patron est souvent une question d'avoir eu la chance d'être à la bonne place le premier.
 B. Avoir la capacité de faire faire aux gens ce qu'il faut ne dépend que peu ou pas de la chance.

17. A. En ce qui concerne les affaires mondiales, la plupart d'entre nous sommes les victimes de forces que nous ne pouvons ni comprendre ni contrôler.
 B. En prenant une part active dans les affaires politiques et sociales, les gens peuvent contrôler les événements mondiaux.
- * 18. A. La plupart des gens ne se rendent pas compte à quel point leur vie est contrôlée par le hasard.
 B. La chance n'existe pas vraiment.
19. A. On devrait toujours admettre volontiers ses erreurs.
 B. Il est habituellement préférable de dissimuler ses erreurs.
20. A. Il est difficile de savoir si une personne vous aime vraiment ou non.
 B. Le nombre de vos amis dépend de votre gentillesse.
21. A. Avec le temps, les mauvaises choses qui nous arrivent sont compensées par les bonnes.
 B. La plupart des malheurs sont le résultat d'un manque de compétence, de l'ignorance, de la paresse ou de ces trois choses.
22. A. Avec suffisamment d'efforts, nous pouvons éliminer la corruption politique.
 B. Il est difficile pour certaines personnes d'avoir beaucoup de contrôle sur ce que font les hommes politiques en fonction.
- * 23. A. Il m'arrive parfois de ne pas comprendre comment les professeurs en arrivent aux notes qu'ils donnent.
 B. Il y a un rapport direct entre combien j'étudie et les notes que j'obtiens.
24. A. Un bon meneur s'attend à ce que les gens décident eux-mêmes ce qu'ils doivent faire.
 B. Un bon meneur laisse clairement entendre à chacun quelles sont ses tâches.
- * 25. A. J'ai souvent l'impression que je n'ai pas beaucoup d'influence sur les choses qui m'arrivent.
 B. Il m'est impossible de croire que la chance ou le hasard joue un rôle important dans ma vie.
26. A. Les gens sont seuls parce qu'ils n'essaient pas de se faire des amis.
 B. Il n'est pas très utile d'essayer de plaire aux gens, s'ils vous aiment, ils vous aiment un point c'est tout.
27. A. On met trop l'accent sur les sports à l'école secondaire.
 B. Les sports d'équipe constituent un excellent moyen de former le caractère.

- * 28. A. Je suis la cause de ce qui m'arrive.
B. Parfois, j'ai l'impression que je n'ai pas suffisamment de contrôle sur le cours que prend ma vie.
29. A. La plupart du temps, je ne peux pas comprendre pourquoi les hommes politiques se comportent comme ils le font.
B. Avec le temps, les gens sont responsables d'un mauvais gouvernement, à la fois au niveau national et local.

Appendix H

Knowledge about Contraceptive Devices and Techniques Test

1. After ejaculation, sperm cells can live, on the average, approximately _____ within the vagina.
 - a. Less than 1 day
 - b. 1 - 2 days
 - c. 3 - 5 days
 - d. 1 week to 10 days
 - e. Do not know

2. It takes about _____ from the time of ejaculation for sperm to get through the cervix and into the uterus.
 - a. 0 - 30 minutes
 - b. 30 - 60 minutes
 - c. 1 - 2 hours
 - d. 24 hours
 - e. Do not know

3. Which of the following contraceptive devices is fitted by a physician?
 - a. Lippes Loop
 - b. Delfen Diaphragm
 - c. Copper 7
 - d. All of the above
 - e. Do not know

4. Which of the following, when used as a douche, can kill sperm cells?
 - a. Coca-cola
 - b. Vinegar
 - c. Soapy water
 - d. All of the above
 - e. Do not know

5. The temperature method of rhythm refers to a drop in basal body temperature of the female

- a. Before menstruation
 - b. Before ovulation
 - c. After menstruation
 - d. After ovulation
 - e. Do not know
6. This method may cause irritation to the vagina.
- a. Intrauterine device
 - b. Withdrawal
 - c. Postcoital douching
 - d. Cervical cap
 - e. Do not know
7. The IUD when properly positioned would be found in the
- a. Cervix
 - b. Vagina
 - c. Uterus
 - d. Urethra
 - e. Do not know
8. The diaphragm covers the
- a. Fallopian tubes
 - b. Cervix
 - c. Vagina
 - d. Ovaries
 - e. Do not know
9. If a woman using a form of contraception is experiencing pain in her lower back, cramps, and spotting, she is probably using
- a. IUD
 - b. Diaphragm
 - c. Cervical cap
 - d. Pill
 - e. Do not know
10. Which of the following is rated the most effective method of contraception?
- a. IUD
 - b. Pill
 - c. Tubal ligation
 - d. Abortion
 - e. Do not know
11. The diaphragm should be left in place at least _____ after sexual intercourse, to obtain maximum contraceptive effectiveness.

- a. 1 - 3 hours
 - b. 7 - 9 hours
 - c. 12 - 15 hours
 - d. 2 - 3 days
 - e. Do not know
12. Which of the following preparations kill sperm?
- a. Creams
 - b. Jellies
 - c. Suppositories
 - d. All of the above
 - e. Do not know
13. When using a condom, to insure maximum contraceptive effectiveness one should
- a. Lubricate it thoroughly with petroleum jelly if it is not the prelubricated type
 - b. Leave a space between the end of the penis and the end of the condom
 - c. Hold onto the open end when withdrawing after ejaculation
 - d. Both b and c
 - e. Do not know
14. Which of the following contraceptives are sold in a drug store without a doctor's prescription?
- a. Lippes Loop
 - b. Copper 7
 - c. Vaginal suppositories
 - d. Morning after pills
 - e. Do not know
15. The IUD should be
- a. Inserted before intercourse and removed several hours later
 - b. Checked regularly to see if it is in place
 - c. Cleaned on a regular basis
 - d. Removed when a woman menstruates
 - e. Do not know
16. In general, a woman's safe period (when she cannot become pregnant even when she has sexual intercourse) is
- a. First 15 days after menstruation ceases
 - b. First 15 days before menstruation begins
 - c. First 5 days before and after menstruation
 - d. First 5 days before and after ovulation
 - e. Do not know

17. A female egg is capable of being fertilized for approximately _____ after it is released.
- 6 - 7 days
 - 4 - 6 days
 - 2 - 3 days
 - 12 hours - 1 day
 - Do not know
18. The main function of the pill is to
- Kill sperm
 - Suppress ovulation
 - Inhibit implantation of the egg
 - Regulate ovulation
 - Do not know
19. The contraceptive practice of withdrawal can be an ineffective method of birth control because
- There can be a small amount of sperm released prior to ejaculation
 - It places great demands on the self control of the sexual partners.
 - It can lead to premature ejaculation
 - It can lead to postmature ejaculation
 - Do not know
20. A contraceptive device as well as a protective against venereal disease is
- IUD
 - Condom
 - Vaginal douche
 - Pill
 - Do not know

1. Après l'éjaculation, le spermatozoïde peut survivre, en général, environ _____ à l'intérieur du vagin.
 - a. Moins d'un jour
 - b. 1 - 2 jours
 - c. 3 - 5 jours
 - d. 1 semaine à dix jours
 - e. Ne sais pas

2. Les spermatozoïdes mettent environ _____, à partir de l'éjaculation, pour traverser le col et pénétrer dans l'utérus.
 - a. 0 - 30 minutes
 - b. 30 - 60 minutes
 - c. 1 - 2 heures
 - d. 24 heures
 - e. Ne sais pas

3. Lequel, parmi les dispositifs contraceptifs suivants, doit être ajusté par un médecin pour trouver la bonne taille.
 - a. Boucle de Lippes
 - b. Diaphragme de Delfen
 - c. 7-Cuivre
 - d. a, b, et c
 - e. Ne sais pas

4. Lorsqu'utilisé comme douche vaginale, _____ peut tuer les spermatozoïdes?
 - a. Le coca-cola
 - b. Le vinaigre
 - c. L'eau savonneuse
 - d. a, b, et c
 - e. Ne sais pas

5. La méthode rythmique-température se rapporte à une baisse de la

11. Le diaphragme devrait demeurer en place au moins _____ après une relation sexuelle.
- 1 - 3 heures
 - 7 - 9 heures
 - 12 - 15 heures
 - 2 - 3 jours
 - Ne sais pas
12. Lesquels, parmi les suivants, tuent les spermatozoïdes?
- Les crèmes
 - Les gelées
 - Les suppositoires
 - a, b, et c
 - Ne sais pas
13. Lorsqu'on utilise un condom, afin d'assurer une efficacité au maximum, on devrait:
- Le lubrifier complètement avec une gelée de pétrole si ce n'est pas un condom pré lubrifié
 - Laisser un espace entre l'extrémité du pénis et celle du condom
 - Tenir l'extrémité supérieure (l'ouverture) lors du retrait après l'éjaculation
 - A la fois b et c
 - Ne sais pas
14. Lesquels, parmi les contraceptifs suivants, sont vendus en pharmacie sans prescription
- Les boucles de Lippes
 - Les 7-Cuivres
 - Les suppositoires vaginaux
 - Les pilules du lendemain
 - Ne sais pas
15. Le stérilet devrait être
- Inséré avant les relations sexuelles et retiré quelques heures après
 - Vérifié régulièrement pour voir s'il est en place
 - Nettoyé régulièrement
 - Retiré lors des menstruations
 - Ne sais pas
16. En général, la période sans danger pour la femme (lorsqu'elle ne peut pas tomber enceinte même si elle a des relations sexuelles) est:

température corporelle de base de la femme:

- a. Avant les menstruations
 - b. Avant l'ovulation
 - c. Après les menstruations
 - d. Après l'ovulation
 - e. Ne sais pas
6. Cette méthode peut causer une irritation vaginale.
- a. Dispositif intra-utérin
 - b. Retrait
 - c. Douche vaginale post-coïtale
 - d. Cape cervicale
 - e. Ne sais pas
7. Lorsque convenablement installé, un stérilet doit se trouver dans:
- a. Le col
 - b. Le vagin
 - c. L'utérus
 - d. L'urètre
 - e. Ne sais pas
8. Le diaphragme recouvre:
- a. Les trompes de Fallope
 - b. Le col
 - c. Le vagin
 - d. Les ovaires
 - e. Ne sais pas
9. Si une femme, utilisant une méthode contraceptive, a des douleurs dans le bas dos, des crampes et des saignements, elle utilise probablement:
- a. Le stérilet
 - b. Un diaphragme
 - c. Une cape cervicale
 - d. La pilule
 - e. Ne sais pas
10. Parmi les méthodes contraceptives suivantes, laquelle évalue-t-on comme étant la plus efficace?
- a. Le stérilet
 - b. La pilule
 - c. La ligature des trompes
 - d. L'avortement
 - e. Ne sais pas

- a. Pendant les premiers 15 jours après la fin des menstruations
 - b. Pendant les premiers 15 jours avant le début des menstruations
 - c. Pendant les premiers 5 jours avant et après les menstruations
 - d. Pendant les premiers 5 jours avant et après l'ovulation
 - e. Ne sais pas
17. Un ovule peut être fécondé pendant environ _____ après sa libération?
- a. 6 - 7 jours
 - b. 4 - 6 jours
 - c. 2 - 3 jours
 - d. 12 heures - 1 jour
 - e. Ne sais pas
18. La principale fonction de la pilule est de:
- a. Tuer les spermatozoïdes
 - b. Supprimer l'ovulation
 - c. Empêcher l'implantation de l'ovule
 - d. Régler l'ovulation
 - e. Ne sais pas
19. Le retrait peut être inefficace en tant que méthode contraceptive parce que:
- a. Il peut y avoir un peu de sperme expulsé avant l'éjaculation
 - b. Cela demande un grand contrôle des partenaires
 - c. Cela peut conduire à l'éjaculation prématurée
 - d. Cela peut conduire à l'éjaculation retardée
20. Ce contraceptif est à la fois une protection contre les maladies vénériennes
- a. Le stérilet
 - b. Le condom
 - c. La douche vaginale
 - d. La pilule
 - e. Ne sais pas

Appendix I
Consent Form

The study in which you are to take part proposes to compare the attitudes of 1) women who are pregnant and wish to have their baby, 2) women who are pregnant and wish to terminate their pregnancy, and 3) women who are contracepting.

This study will provide important information about these groups of patients and their partners for both the medical and educational professions which, it is hoped, will provide a basis for better health care.

The information which you provide will be considered completely confidential. You may withdraw from the study at any time.

Your signature below will indicate that you understand the above and that you consent to participate in this study.

Signature _____

Date _____

File No. _____

Doctor _____

Examiner _____

L'étude dans laquelle vous allez prendre part se propose de comparer les attitudes de 1) femmes enceintes qui veulent avoir leurs bébés, 2) femmes enceintes qui veulent mettre fin à leurs grossesses, 3) femmes qui utilisent une des méthodes contraceptives suivantes: la pilule, le stérilet, le diaphragme ou le condom.

L'étude suivante fournira des informations importantes sur ces groupes de patientes et leurs partenaires aux professions médicales et éducatives. On espère que cette étude sera la base pour de meilleurs soins de santé.

L'information que vous nous procurez sera complètement confidentielle. Vous pouvez vous retirer de l'étude à n'importe quel moment.

Votre signature indiquera que vous comprenez ce que vous avez lu et que vous consentez à prendre part à l'étude.

Signature _____

Examineur _____

Date _____

No. de dossier _____

Docteur _____

Appendix J

Abortion Patient Questionnaire File Number _____
 Date _____
 Examiner _____
 LMP _____
 Weeks Pregnant _____
 Scorer _____
 Doctor _____

1. What is your primary language?

- | | |
|-------------------------|---|
| A. English | 1 |
| B. French | 2 |
| C. Other, specify _____ | 3 |

2. What is your age? _____

3. How many years of school did you complete? _____

4. What is your occupation? _____

- | | |
|---------------|---|
| A. Full-time | 1 |
| B. Part-time | 2 |
| C. Unemployed | 3 |

Are you a student?

- | | |
|-----------------|---|
| No | 0 |
| Full-time | |
| A. High school | 1 |
| B. University | 2 |
| C. Postgraduate | 3 |
| Part-time | |
| D. High school | 4 |
| E. University | 5 |
| F. Postgraduate | 6 |

5. What is your religion?

- | | |
|-------------------------|---|
| A. Catholic | 1 |
| B. Protestant | 2 |
| C. Jewish | 3 |
| D. Other, specify _____ | 4 |
| E. None | 5 |

6. How strong would you say your religious beliefs are?

- | | |
|----------------|---|
| A. Very weak | 1 |
| B. Weak | 2 |
| C. Don't know | 3 |
| D. Strong | 4 |
| E. Very strong | 5 |
7. What is your marital status?
- | | |
|--------------|---|
| A. Single | 1 |
| B. Engaged | 2 |
| C. Married | 3 |
| D. Divorced | 4 |
| E. Widowed | 5 |
| F. Separated | 6 |
- Husband's baby 1
 Partner's baby 2
 Another's baby 3
- Are you cohabiting?
- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |
8. What is the primary language of your partner?
- | | |
|-------------------------|---|
| A. English | 1 |
| B. French | 2 |
| C. Other, specify _____ | 3 |
9. What is the age of your partner? _____
10. How many years of school did your partner complete? _____
11. What is his occupation? _____
- Is he a student?
- | | |
|--------------------------|---|
| No | 0 |
| Full-time A. High school | 1 |
| B. University | 2 |
| C. Postgraduate | 3 |
| Part-time D. High school | 4 |
| E. University | 5 |
| F. Postgraduate | 6 |
12. What is his religion?
- | | |
|---------------|---|
| A. Catholic | 1 |
| B. Protestant | 2 |

- C. Jewish 3
- D. Other, specify _____ 4
- E. None 5
- F. Don't know 6

13. How strong would you say his religious beliefs are?

- A. Very weak 1
- B. Weak 2
- C. Don't know 3
- D. Strong 4
- E. Very strong 5

14. What is your partner's marital status?

- A. Single 1
- B. Engaged 2
- C. Married 3
- D. Divorced 4
- E. Widowed 5
- F. Separated 6

15. Are you currently involved with him?

- A. No 1
- B. Yes 2

16. How long have you been involved with him?

Days _____
 Months _____
 Years _____

Was this a one night stand?

- A. No 1
- B. Yes 2

17. What is/was the quality of this relationship?

- A. Very poor 1
- B. Poor 2
- C. Mixed 3
- D. Satisfactory 4
- E. Highly satisfactory 5

18. Have you ever used any contraceptive methods?

- A. No 1
- B. Yes 2

If yes, specify which methods used.

Pills	1
Condom	2
IUD, coil, loop	3
Withdrawal	4
Rhythm	5
Diaphragm	6
Foam	7
Other, specify _____	8

19. Did you want to become pregnant?

A. No	1
B. Yes	2
C. Don't know	3

20. Were you using a contraceptive method at the time you became pregnant?

A. No	1
If no, specify reason	

Lack of information	1
Didn't know where to get contraceptive devices	2
Felt safe during that time	3
Too inconvenient	4
Opposite sex was responsible	5
Too embarrassing to get contraceptive device	6
Didn't want to appear as though prepared to have sex	7
Wanted to be spontaneous	8
Side effects	9
Not planning to have sex	10
Partner objection	11
Thought you could not get pregnant	12
Unavailable	13
Broke up with partner	14
Afraid parents would find out	15
Doctor suggested stopping method	16
Afraid to continue after long use	17
Wanted to get pregnant	18
Religious reasons	19
Other, specify _____	20

B. Yes	2
If yes, specify method	

Pills	1
Condom	2
IUD, coil, loop	3

Withdrawal	4
Rhythm (safe time)	5
Diaphragm	6
Foam	7
Other, specify _____	8

C. How many times do you have sexual relations per month?

21. How do you feel about your decision to have an abortion?

- | | |
|----------------------|---|
| A. Strongly negative | 1 |
| B. Negative | 2 |
| C. Mixed feelings | 3 |
| D. Positive | 4 |
| E. Strongly positive | 5 |

22. Does your partner know you are pregnant?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, how did he react when you told him you were pregnant?

- | | |
|------------------------|---|
| A. Very unhappy | 1 |
| B. Unhappy | 2 |
| C. Mixed feelings | 3 |
| D. Happy | 4 |
| E. Very happy | 5 |
| F. Partner isn't aware | 6 |

23. How was the decision to have an abortion reached?

- | | |
|------------------------------------|---|
| A. You decided alone | 1 |
| B. You talked it over with partner | 2 |
| C. Consulted with others | 3 |
| D. Partner or parents decided | 4 |

24. Does your partner know about your decision to have an abortion?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, how does he feel about the abortion?

- | | |
|---------------------|---|
| A. Strongly opposed | 1 |
| B. Opposed | 2 |
| C. Undecided | 3 |

- D. In favour 4
 E. Strongly in favour 5
 F. Partner isn't aware 6

25. What is your main reason for your decision to have an abortion?

- Not married 1
 Do not want to raise a child alone 2
 Do not want a baby now 3
 Never want to have children 4
 Family is complete-want no more children 5
 Fear of having to stop school 6
 Fear of friends finding out 7
 Fear of losing job 8
 Interferes with career plans 9
 Don't want parents to know 10
 Isn't partner's baby 11
 Partner does not want a child 12
 Financial reasons 13
 Would have to move to a larger apartment/house 14
 Endangers mental health 15
 Fear of child being deformed 16
 Endangers physical health 17
 Too young to have a child 18
 Too old to have a child 19
 Other, specify _____ 20

26. Did any problems with family, friends, or physician make you think you might not get an abortion?

- A. No 1
 B. Yes 2

27. Have you ever been pregnant before?

- A. No 1
 B. Yes 2

If yes, how many pregnancies before this one? _____

How many children do you have now? _____

How many miscarriages have you had? _____

28. Have you ever had an abortion before?

- A. No 1
 B. Yes 2

If yes, how many abortions have you had? _____

How long ago was your most recent abortion? _____

29. Are you planning on having children in the future?

- A. No 1
 B. Yes 2
 C. Undecided 3 If yes, how many? _____

30. Are you planning on using contraceptives in the future?

- | | | | |
|-----------------------|---|------------------------|----|
| A. No | 1 | B. Yes | 2 |
| If no, specify reason | | If yes, specify method | |
| Not applicable | 0 | Pills | 1 |
| No more intercourse | 1 | Condom | 2 |
| Male responsible | 2 | IUD, coil, loop | 3 |
| Side effects | 3 | Withdrawal | 4 |
| Religious reasons | 4 | Rhythm | 5 |
| Inconvenient | 5 | Diaphragm | 6 |
| Spontaneity | 6 | Foam | 7 |
| Don't want to | 7 | Other _____ | 8 |
| Want to get preg- | 8 | Undecided | 9 |
| nant | | Combination | 10 |
| Other _____ | 9 | | |

31. Did anyone accompany you today (other than partner)?

- A. No 1
 B. Yes 2

If yes, who?

- Nobody 0
 Information not available 1
 Friend(s) 2
 Father, mother 3
 Other relative(s) 4
 Professional 5
 Other _____ 6

32. Partner accompanied woman to hospital

- A. No 1
 B. Yes 2

If no, can we contact him? _____ Name _____
 Phone _____

Partner not aware _____

33. Did you come from out of town to this hospital?

- A. No 1 B. Yes 2

Avortement

No. de dossier _____

Date _____

Examineur _____

LMP _____

Sem Enc _____

Médecin _____

Vérificateur _____

1. Quelle est votre langue première?

- | | |
|--------------------------|---|
| A. Anglais | 1 |
| B. Français | 2 |
| C. Autre, précisez _____ | 3 |

2. Quel est votre âge? _____

3. Combien d'années de scolarité avez-vous terminées? _____

4. Quelle est votre profession? / _____

- | | |
|------------------|---|
| A. Temps complet | 1 |
| B. Temps partiel | 2 |
| C. En chômage | 3 |

Etes-vous une étudiante?

- | | | |
|---------------|------------------------|---|
| Non | 0 | |
| Temps complet | A. Ecole
secondaire | 1 |
| | B. Université | 2 |
| | C. Post-gradué | 3 |
| Temps partiel | D. Ecole
secondaire | 4 |
| | E. Université | 5 |
| | F. Post-gradué | 6 |

5. Quelle est votre religion?

- | | |
|--------------------------|---|
| A. Catholique | 1 |
| B. Protestante | 2 |
| C. Juive | 3 |
| D. Autre, précisez _____ | 4 |
| E. Aucune | 5 |

6. Quelle est, selon vous, l'intensité de votre croyance religieuse?

- | | |
|----------------|---|
| A. Très faible | 1 |
| B. Faible | 2 |
| C. Ne sais pas | 3 |

- D. Intense 4
E. Très intense 5

7. Quel est votre état civil?

- A. Célibataire 1
B. Fiancée 2
C. Mariée 3
D. Divorcée 4
E. Veuve 5
F. Séparée 6

- L'enfant de votre mari? 1
L'enfant de votre partenaire? 2
L'enfant de quelqu'un d'autre? 3

Habitez-vous avec votre partenaire?

- A. Non 1
B. Oui 2

8. Quelle est la langue première de votre partenaire?

- A. Anglais 1
B. Français 2
C. Autre, précisez _____ 3

9. Quel est l'âge de votre partenaire? _____

10. Combien d'années de scolarité votre partenaire a-t-il terminées?

11. Quelle est sa profession? _____

Est-il un étudiant?

- Non 0
Temps complet A. Ecole 1
 secondaire
 B. Université 2
 C. Post-gradué 3
Temps partiel D. Ecole 4
 secondaire
 E. Université 5
 F. Post-gradué 6

12. Quelle est sa religion?

- A. Catholique 1
B. Protestante 2

- | | |
|--------------------------|---|
| C. Juive | 3 |
| D. Autre, précisez _____ | 4 |
| E. Aucune | 5 |
| F. Ne sais pas | 6 |

13. Quelle est, selon vous, l'intensité de sa croyance religieuse?

- | | |
|-----------------|---|
| A. Très faible | 1 |
| B. Faible | 2 |
| C. Ne sais pas | 3 |
| D. Intense | 4 |
| E. Très intense | 5 |

14. Quel est l'état civil de votre partenaire?

- | | |
|----------------|---|
| A. Célibataire | 1 |
| B. Fiancé | 2 |
| C. Marié | 3 |
| D. Divorcé | 4 |
| E. Veuf | 5 |
| F. Séparé | 6 |

15. Etes-vous présentement en rapport avec lui?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

16. Depuis combien de temps êtes-vous en rapport avec lui?

Jours _____
 Mois _____
 Années _____

Est-ce que c'était une affaire d'une nuit?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

17. Quelle est/a été la qualité de cette relation?

- | | |
|-----------------------|---|
| A. Très médiocre | 1 |
| B. Médiocre | 2 |
| C. Mélangée | 3 |
| D. Satisfaisante | 4 |
| E. Très satisfaisante | 5 |

18. Avez-vous déjà utilisé des méthodes contraceptives?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

Si oui, précisez quelles méthodes

Pilules	1
Condom	2
DIU, stérilets	3
Retrait	4
Rythme (calendrier, température)	5
Diaphragme	6
Spermicides (mousse, crème)	7
Autre, précisez _____	8

19. Voulez-vous tomber enceinte?

A. Non	1
B. Oui	2
C. Ne sais pas	3

20. Utilisez-vous une méthode contraceptive au moment de tomber enceinte?

A. Non
Dans ce cas, précisez la raison

Manque de raison	1
Ne savais pas où me procurer des contraceptifs	2
Me sentais en sécurité à ce moment-là	3
Trop embarrassant, ennuyant	4
Le sexe opposé a été responsable	5
Trop embarrassant pour me procurer un contraceptif	6
Ne voulais pas paraître comme si j'étais prête à avoir du sexe	7
Voulais être spontanée	8
Effets secondaires	9
Ne songeais pas à avoir du sexe	10
Objection de la part du partenaire	11
Ne pensiez pas que vous pourriez tomber enceinte	12
Non disponibilité de contraceptifs	13
Rupture avec le partenaire	14
Crainte que les parents ne s'en aperçoivent	15
Le médecin avait suggéré de cesser d'utiliser la méthode	16
Crainte de continuer après un long usage	17
Désirais tomber enceinte	18
Raisons religieuses	19
Autre, précisez _____	20

B. Oui
Dans ce cas, précisez la méthode

Pilules	1
Condom	2
IUD, stérilets	3
Retrait	4
Rythme (calendrier, température)	5
Diaphragme	6
Spermicides (mousse, crème)	7
Autre, précisez _____	8

C. Combien de fois par mois avez-vous des relations sexuelles? _____

21. Comment voyez-vous votre décision de vous faire avorter?

A. D'une façon très négative	1
B. D'une façon négative	2
C. Sentiments mélangés	3
D. D'une façon positive	4
E. D'une façon très positive	5

22. Votre partenaire, sait-il que vous êtes enceinte?

A. Non	1
B. Oui	2

Si oui, comment a-t-il réagi quand vous lui avez dit que vous étiez enceinte?

A. Fortement opposé	1
B. Opposé	2
C. Indécis	3
D. En faveur	4
E. Fortement en faveur	5
F. Partenaire n'est pas au courant	6

23. Comment avez-vous pris la décision de vous faire avorter?

A. Vous avez pris la décision seule	1
B. Vous en avez parlé avec votre partenaire	2
C. Vous avez consulté d'autres gens	3
D. Votre partenaire ou vos parents ont pris la décision	4

24. Votre partenaire, est-il au courant que vous avez décidé de vous faire avorter?

- A. Non 1
B. Oui 2

Si oui, que pense-t-il de l'avortement?

- A. Fortement opposé 1
B. Opposé 2
C. Indécis 3
D. En faveur 4
E. Fortement en faveur 5
F. Partenaire n'est pas au courant 6

25. Pourquoi avez-vous décidé principalement de vous faire avorter?

- Ne voulais pas me marier; pas mariée 1
Ne voulais pas élever un enfant seule 2
Né voulais pas un bébé maintenant 3
Ne veux jamais avoir d'enfant 4
Famille complète-ne veux plus d'enfants 5
Crainte d'avoir à cesser mes études 6
Crainte que mes amis le découvrent 7
Crainte de perdre mon emploi 8
Nuit à mes plans de carrière 9
Ne veux pas que mes parents le sachent 10
Ce n'est pas le bébé de mon partenaire 11
Mon partenaire ne veut pas l'enfant 12
Raisons financières 13
Devrais emménager dans un(e) plus grand(e) appartement/maison 14
Met en danger ma santé mentale 15
Crainte d'avoir un enfant difforme 16
Met en danger ma santé physique 17
Trop jeune pour avoir un enfant 18
Trop vieille pour avoir un enfant 19
Autre, précisez 20

26. Est-ce que des problèmes avec votre famille, vos amis ou votre médecin vous ont fait penser que vous ne pourriez pas vous faire avorter?

- A. Non 1
B. Oui 2

27. Avez-vous été enceinte auparavant?

- A. Non 1
B. Oui 2

Si oui, combien de grossesses avez-vous eues avant celle-ci? _____
 Combien d'enfants avez-vous maintenant? _____
 Combien de fausses couches avez-vous eues? _____

28. Avez-vous eu un avortement auparavant?

- A. Non 1
 B. Oui 2

Si oui, combien d'avortements avez-vous eus? _____
 De quand date le plus récent avortement? _____

29. Avez-vous l'intention d'avoir des enfants à l'avenir?..

- A. Non 1
 B. Oui 2 Si oui, combien? _____
 C. Indécis 3

30. Avez-vous l'intention d'utiliser des méthodes contraceptives à l'avenir?

- | | | | |
|-----------------------------|---|---------------------|----|
| A. Non | 1 | B. Oui | 2 |
| Si non, précisez | | Si oui, précisez | |
| Ne s'applique pas | 0 | Pilules | 1 |
| Plus de relations sexuelles | 1 | Condom | 2 |
| Partenaire responsable | 2 | DIU, stérilets | 3 |
| Effets secondaires | 3 | Retrait | 4 |
| Raisons religieuses | 4 | Rythme (calendrier) | 5 |
| Inconvénient | 5 | Diaphragme | 6 |
| Veux être spontanée | 6 | Spermicides | 7 |
| Ne veux pas | 7 | (mousse) | 7 |
| Veux tomber enceinte | 8 | Autre _____ | 8 |
| Autre _____ | 9 | Indécis | 9 |
| | | Combinaison | 10 |
| C. Indécis | 3 | | |

31. Est-ce que quelqu'un vous a accompagné à l'hôpital (autre que votre partenaire)?

- A. Non 1
 B. Oui 2

Si oui, qui?

- Personne 0
 Pas d'information 1
 Ami(e) (s) 2
 Père, mère 3

Autre(s)-parent(s) 4
Professionel 5
Autre _____ 6

32. Partenaire a accompagné la patiente à l'hôpital?

Non 1
Oui 2

Sinon, peut-on entrer en contact avec lui?

Partenaire n'est pas au courant _____

Nom _____
Téléphone _____

33. Venez-vous de l'extérieur de la ville?

A. Non 1
B. Oui 2

Appendix K

IUD Patient Questionnaire

File number _____

Date _____

Examiner _____

Doctor _____

Scorer _____

1. What is your primary language?

- A. English 1
- B. French 2
- C. Other, specify _____ 3

2. What is your age? _____

3. How many years of school did you complete? _____

4. What is your occupation? _____

- A. Full-time 1
- B. Part-time 2
- C. Unemployed 3

Are you a student?

- No 0
- Full-time
 - A. High school 1
 - B. University 2
 - C. Postgraduate 3
- Part-time
 - D. High school 4
 - E. University 5
 - F. Postgraduate 6

5. What is your religion?

- A. Catholic 1
- B. Protestant 2
- C. Jewish 3
- D. Other, specify _____ 4
- E. None 5

6. How strong would you say your religious beliefs are?

- A. Very weak 1
- B. Weak 2
- C. Don't know 3

- D. Strong 4
- E. Very strong 5

7. What is your marital status?

- A. Single 1
- B. Engaged 2
- C. Married 3
- D. Divorced 4
- E. Widowed 5
- F. Separated 6
- G. Cohabiting 7

8. What is your partner's first language?

- A. English 1
- B. French 2
- C. Other _____ 3

9. What is the age of your partner? _____

10. How many years of school did your partner complete? _____

11. What is his occupation? _____

- Is he a student?
- No 0
 - Full-time
 - A. High school 1
 - B. University 2
 - C. Postgraduate 3
 - Part-time
 - D. High school 4
 - E. University 5
 - F. Postgraduate 6

12. What is his religion?

- A. Catholic 1
- B. Protestant 2
- C. Jewish 3
- D. Other, specify _____ 4
- E. None 5
- F. Don't know 6

13. How strong would you say his religious beliefs are?

- A. Very weak 1
- B. Weak 2
- C. Don't know 3
- D. Strong 4
- E. Very strong 5

14. What is your partner's marital status?

- | | |
|---------------|---|
| A. Single | 1 |
| B. Engaged | 2 |
| C. Married | 3 |
| D. Divorced | 4 |
| E. Widowed | 5 |
| F. Separated | 6 |
| G. Cohabiting | 7 |

15. Are you currently involved with him?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

16. How long have you been involved with him?

Days _____
 Months _____
 Years _____

17. What is/was the quality of this relationship?

- | | |
|------------------------|---|
| A. Very poor | 1 |
| B. Poor | 2 |
| C. Mixed | 3 |
| D. Satisfactory | 4 |
| E. Highly satisfactory | 5 |

18. Have you ever used any contraceptive methods?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, specify which methods used.

- | | |
|----------------------|---|
| Pills | 1 |
| Condom | 2 |
| IUD, coil, loop | 3 |
| Withdrawal | 4 |
| Rhythm | 5 |
| Diaphragm | 6 |
| Foam | 7 |
| Other, specify _____ | 8 |

C. How many times do you have sexual relations per month?

19. How do you feel about your decision to have an IUD inserted?

- | | |
|----------------------|---|
| A. Strongly negative | 1 |
| B. Negative | 2 |
| C. Mixed feelings | 3 |
| D. Positive | 4 |
| E. Strongly positive | 5 |

20. Does your partner know about your decision to have an IUD inserted?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, how does he feel?

- | | |
|-----------------------|---|
| A. Strongly opposed | 1 |
| B. Opposed | 2 |
| C. Undecided | 3 |
| D. In favour | 4 |
| E. Strongly in favour | 5 |

21. How was the decision to have an IUD inserted reached?

- | | |
|------------------------------------|---|
| A. You decided alone | 1 |
| B. You talked it over with partner | 2 |
| C. Consulted with others | 3 |
| D. Partner decided | 4 |

22. Have you ever been pregnant before?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, how many pregnancies before? _____
 How many children do you have? _____
 How many miscarriages have you had? _____

23. Have you ever had an abortion?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, how many abortions have you had? _____
 How long ago was the most recent abortion? _____

24. Are you planning on having children in the future?

- | | |
|--------------|---|
| A. No | 1 |
| B. Yes | 2 |
| C. Undecided | 3 |
- If yes, how many? _____

25. What is the main reason for your decision to get an IUD?

- | | |
|---|---|
| A. Failure of other methods | 1 |
| B. Side effects of pill | 2 |
| C. Forgetting to take pill | 3 |
| D. Spontaneity | 4 |
| E. Don't want to get pregnant | 5 |
| F. Inconvenience of other methods | 6 |
| G. Family is complete - want no more children | 7 |
| H. Never want children | 8 |
| I. Other, specify _____ | 9 |

26. May we contact your partner?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

If yes, name _____ Doctor _____

Phone _____

27. Did you come from out of town to this hospital?

- | | |
|--------|---|
| A. No | 1 |
| B. Yes | 2 |

Stérilet

No. de dossier _____
 Date _____
 Examineur _____
 Médecin _____
 Vérificateur _____

1. Quelle est votre langue première?

- | | |
|--------------------------|---|
| A. Anglais | 1 |
| B. Français | 2 |
| C. Autre, précisez _____ | 3 |

2. Quel âge avez-vous? _____

3. Combien d'années de scolarité avez-vous terminées? _____

4. Quelle est votre profession? _____

- | | |
|------------------|---|
| A. Temps complet | 1 |
| B. Temps partiel | 2 |
| C. En chômage | 3 |

Etes-vous une étudiante? (

- | | | |
|---------------|------------------------|---|
| Non | 0 | |
| Temps complet | A. Ecole
secondaire | 1 |
| | B. Université | 2 |
| | C. Post-gradué | 3 |
| Temps partiel | D. Ecole
secondaire | 4 |
| | E. Université | 5 |
| | F. Post-gradué | 6 |

5. Quelle est votre religion?

- | | |
|--------------------------|---|
| A. Catholique | 1 |
| B. Protestante | 2 |
| C. Juive | 3 |
| D. Autre, précisez _____ | 4 |
| E. Aucune | 5 |

6. (Quelle est, selon vous, l'intensité de votre croyance religieuse?

- | | |
|-----------------|---|
| A. Très faible | 1 |
| B. Faible | 2 |
| C. Ne sais pas | 3 |
| D. Intense | 4 |
| E. Très intense | 5 |

7. Quel est votre état civil?

- | | |
|----------------|---|
| A. Célibataire | 1 |
| B. Fiancée | 2 |
| C. Mariée | 3 |
| D. Divorcée | 4 |
| E. Veuve | 5 |
| F. Séparée | 6 |

Habitez-vous avec votre partenaire?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

8. Quelle est la langue première de votre partenaire?

- | | |
|--------------------------|---|
| A. Anglais | 1 |
| B. Français | 2 |
| C. Autre, précisez _____ | 3 |

9. Quel âge a votre partenaire? _____

10. Combien d'années de scolarité votre partenaire a-t-il terminées? _____

11. Quelle est sa profession? _____

Est-il un étudiant?

- | | | |
|---------------|---------------------|---|
| Non | 0 | |
| Temps complet | A. Ecole secondaire | 1 |
| | B. Université | 2 |
| | C. Post-gradué | 3 |
| Temps partiel | D. Ecole secondaire | 4 |
| | E. Université | 5 |
| | F. Post-gradué | 6 |

12. Quelle est sa religion?

- | | |
|--------------------------|---|
| A. Catholique | 1 |
| B. Protestante | 2 |
| C. Juive | 3 |
| D. Autre, précisez _____ | 4 |
| E. Aucune | 5 |
| F. Ne sais pas | 6 |

13. Quelle est, selon vous, l'intensité de sa croyance religieuse?

- | | |
|-----------------|---|
| A. Très faible | 1 |
| B. Faible | 2 |
| C. Ne sais pas | 3 |
| D. Intense | 4 |
| E. Très intense | 5 |

14. Quel est l'état civil de votre partenaire?

- | | |
|----------------|---|
| A. Célibataire | 1 |
| B. Fiancé | 2 |
| C. Marié | 3 |
| D. Divorcé | 4 |
| E. Veuf | 5 |
| F. Séparé | 6 |

15. Etes-vous présentement en rapport avec lui?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

16. Depuis combien de temps êtes-vous en rapport avec lui?

Jours ___ ___
 Mois ___ ___
 Années ___ ___

17. Quelle est/a été la qualité de cette relation?

- | | |
|-----------------------|---|
| A. Très médiocre | 1 |
| B. Médiocre | 2 |
| C. Mélangée | 3 |
| D. Satisfaisante | 4 |
| E. Très satisfaisante | 5 |

18. Avez-vous déjà utilisé des méthodes contraceptives?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

Si oui, précisez quelles méthodes.

- | | |
|-----------------------------|---|
| Pilules | 1 |
| Condom | 2 |
| DIU, stérilet | 3 |
| Retrait | 4 |
| Rythme (Calendrier) | 5 |
| Diaphragme | 6 |
| Spermicides (Mousse, crème) | 7 |
| Autre, précisez _____ | 8 |

C. Combien de fois par mois avez-vous des relations sexuelles? _____

19. Comment voyez-vous votre décision de vous faire insérer un DIU?

- | | |
|------------------------------|---|
| A. D'une façon très négative | 1 |
| B. D'une façon négative | 2 |
| C. Sentiments mélangés | 3 |
| D. D'une façon positive | 4 |
| E. D'une façon très positive | 5 |

20. Est-ce que votre partenaire est au courant de votre décision de vous faire insérer un DIU?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

Si oui, qu'en pense-t-il?

- | | |
|------------------------------------|---|
| A. Fortement opposé | 1 |
| B. Opposé | 2 |
| C. Indécis | 3 |
| D. En faveur | 4 |
| E. Fortement en faveur | 5 |
| F. Partenaire n'est pas au courant | 6 |

21. Comment avez-vous pris la décision de vous faire insérer un DIU?

- | | |
|---|---|
| A. Vous avez pris la décision seule | 1 |
| B. Vous en avez parlé avec votre partenaire | 2 |
| C. Vous avez consulté d'autres gens | 3 |
| D. Votre partenaire a pris la décision | 4 |

22. Avez-vous été enceinte auparavant?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

Si oui, combien de grossesses avez-vous eues auparavant? _____

Combien d'enfants avez-vous? _____

Combien de fausses couches avez-vous eues? _____

23. Avez-vous eu un avortement auparavant?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

Si oui, combien d'avortements avez-vous eus? _____

De quand date le plus récent avortement? _____

24. Avez-vous l'intention d'avoir des enfants à l'avenir?

- | | |
|------------|---|
| A. Non | 1 |
| B. Oui | 2 |
| C. Indécis | 3 |

Si oui, combien? _____

25. Pour quelle raison principalement avez-vous décidé de vous faire insérer un stérilet?

- | | |
|--|---|
| A. Echec des autres méthodes | 1 |
| B. Effets secondaires de la pilule | 2 |
| C. Trop facile d'oublier la pilule | 3 |
| D. Voulais être spontanée | 4 |
| E. Ne voulais pas tomber enceinte | 5 |
| F. Les autres méthodes sont mal commodes | 6 |
| G. Famille complète-ne veux plus d'enfants | 7 |
| H. Ne veux jamais avoir d'enfants | 8 |
| I. Autre, précisez _____ | 9 |

26. Pouvons-nous entrer en contact avec votre partenaire?

- | | |
|--------|--|
| A. Non | |
| B. Oui | |

Si oui, nom _____
numéro de téléphone _____

27. Venez-vous de l'extérieur de la ville?

- | | |
|--------|---|
| A. Non | 1 |
| B. Oui | 2 |

Appendix L
Demographic Variables of the Abortion and IUD Groups

Group	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
Language						
N=	51	44	147	206	43	66
Age						
M	26.80	27.84	23.34	24.45	25.12	23.02
SD	6.3	5.9	5.9	5.8	6.0	3.8
Years of Education						
M	13.92	13.21	12.75	12.66	14.28	14.79
SD	3.0	2.9	2.4	2.7	2.2	3.4
Number of Children						
M	.76	.80	.48	.63	.53	.17
SD	1.0	1.1	.9	1.1	1.0	.5
Religious Intensity						
M	2.31	2.64	2.42	2.58	2.35	2.18
SD	1.3	1.4	1.2	1.3	1.3	1.3
Marital Status						
Married	25%	23%	20%	23%	28%	15%
Not married	75%	77%	80%	77%	72%	85%
Sexually experienced	100%	100%	100%	100%	100%	100%

Appendix L continues.

Appendix L continued.

Group	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
Language	51	44	147	206	43	66
N=						
Occupational Status on Blishen Scale						
Middle	33%	43%	29%	32%	33%	29%
Working	22%	23%	20%	25%	28%	17%
Unemployed*	45%	34%	50%	43%	40%	55%

*This category includes students and housewives.

Note: Percents may not add to 100 because of rounding.

Appendix M
Correlation Coefficients for Dependent Measures
and Demographic Variables

<u>Demographic Variables</u>	<u>Age</u>	<u>Years of Education</u>	<u>Number of Children</u>
<u>Attitude Scales (N=550)</u>			
Sex Roles	-.01	.43*	-.19*
Sexuality	.01	.37*	-.24*
Contraception	.06	.39*	-.16*
Abortion	.15*	.28*	-.06
<u>IE Scores (N=549)</u>			
Rotter	.08*	.06	.09*
Mirels	.08*	.06	.12*
<u>DPI Scores (N=557)</u>			
Insomnia	.02	-.21*	.11*
Headache proneness	.01	-.22*	.09
Broodiness	-.11*	-.23*	.01
Depression	-.02	-.25*	.05
Disorganization of thinking	-.03	-.30*	.07
Feelings of unreality	-.11*	-.24*	-.02
Health concerns	-.03	-.22*	.03
Hypochondriasis	-.01	-.28*	.08
Impulsivity	-.15*	-.08	-.08
Mood fluctuation	-.16*	-.07	-.14*
Neurotic disorganization	-.07	-.10	-.01
Panic reaction	-.05	-.24*	.04
Perceptual distortion	-.11	-.19*	.01
Self depreciation	-.10	-.30*	.07
Somatic complaints	-.02	-.21*	.04

Appendix M continues.

Appendix M continued.

<u>Demographic Variables</u>	<u>Age</u>	<u>Years of Education</u>	<u>Number of Children</u>
<u>Relationship Variables (N=545)</u>			
Length	.57*	-.01	.58*
Quality	-.06	.05	-.01
<u>Communication Variables (N=448)</u>			
Tells re: pregnancy	.01	.02	
Tells re: abortion	.01	.02	

*Significant according to the Bonferroni procedure with Alpha set at $p < .10$.

Appendix N

Mancova Results and Univariate Tests for Attitude Scales
and DPI Scores Adjusted for Years of EducationTable 1
Mancova Results and Univariate Tests for Attitude Scales
Adjusted for Years of Education

Mancova Tests				
Effect	df hyp	df err	F	p
Group	8	1094	8.71	< .00001
Language	4	547	1.13	ns
Interaction	8	1094	.98	ns
Univariate Tests for Group				
Variable	df	F	p	
Sex Roles	2,550	3.04	< .05	
Sexuality	2,550	5.56	< .005	
Contraception	2,550	7.28	< .001	
Abortion	2,550	3.42	< .05	
Univariate Tests for Language				
Variable	df	F	p	
Sex Roles	1,550	2.58	ns	
Sexuality	1,550	.16	ns	
Contraception	1,550	.21	ns	
Abortion	1,550	.17	ns	
Univariate Tests for Group x Language				
Variable	df	F	p	
Sex Roles	2,550	1.26	ns	
Sexuality	2,550	1.04	ns	
Contraception	2,550	.14	ns	
Abortion	2,550	.74	ns	

Appendix N continues.

Appendix N continued.

Table 2.
 Mancova Results and Univariate Tests for DPI Scores
 Adjusted for Years of Education

Mancova Tests				
Effect	df hyp	df err	F	p
Group	32	1070	1.75	.005
Language	16	535	4.34	.00001
Interaction	32	1070	.72	ns
Univariate Tests for Group				
Variable	df	F	p	
Insomnia	2,550	5.03	.005	
Headache proneness	2,550	1.12	ns	
Broodiness	2,550	.71	ns	
Depression	2,550	.63	ns	
Disorganization of thinking	2,550	1.50	ns	
Feelings of unreality	2,550	.02	ns	
Health concerns	2,550	6.79	.001	
Hypochondriasis	2,550	4.38	.01	
Impulsivity	2,550	1.97	ns	
Mood fluctuation	2,550	.38	ns	
Neurotic disorganization	2,550	.02	ns	
Panic reaction	2,550	2.27	<.10	
Perceptual distortion	2,550	3.22	.05	
Self depreciation	2,550	.06	ns	
Somatic complaints	2,550	5.25	.005	

Table 2 continues.

Table 2 continued.

Univariate Tests for Language

Variable	df	F	p
Insomnia	1,550	4.00	<.05
Headache proneness	1,550	.01	ns
Broodiness	1,550	15.64	.0001
Depression	1,550	.22	ns
Disorganization of thinking	1,550	9.98	<.005
Feelings of unreality	1,550	29.69	<.00001
Health concerns	1,550	1.67	ns
Hypochondriasis	1,550	20.86	<.00001
Impulsivity	1,550	5.90	<.05
Mood fluctuation	1,550	.68	ns
Neurotic disorganization	1,550	1.96	ns
Panic reaction	1,550	10.07	<.005
Perceptual distortion	1,550	31.03	<.00001
Self depreciation	1,550	6.26	<.05
Somatic complaints	1,550	4.06	<.05

Univariate Tests for Group x Language

Variable	df	F	p
Insomnia	2,550	.47	ns
Headache proneness	2,550	2.14	ns
Broodiness	2,550	.33	ns
Depression	2,550	.51	ns
Disorganization of thinking	2,550	.03	ns
Feelings of unreality	2,550	.03	ns
Health concerns	2,550	.02	ns
Hypochondriasis	2,550	.67	ns
Impulsivity	2,550	.11	ns
Mood fluctuation	2,550	.56	ns
Neurotic disorganization	2,550	.43	ns
Panic reaction	2,550	.16	ns
Perceptual distortion	2,550	1.84	ns
Self depreciation	2,550	1.00	ns
Somatic complaints	2,550	.19	ns

Appendix 0
 Statistical Analyses for Subsamples Matched for Years of Education

Table 1
 Demographic Variables of the Abortion and IUD Subsamples

Group	Repeaters		Initial		IUD Patients	
	Anglophone	Francoophone	Anglophone	Francoophone	Anglophone	Francoophone
N=	45	35	147	202	26	38
Years of Education	M 13.31	M 12.35	M 12.75	M 12.66	M 12.93	M 13.00
	SD 2.4	SD 2.4	SD 2.4	SD 2.7	SD 1.6	SD 1.7

Appendix 0 continues.

Appendix 0 continued.

Table 2
 Manova Results and Univariate Tests for Attitude Measures
 for Matched Subsamples

Manova Tests				
Effect	df hyp	df err	F	p
Group	8	968	6.16	<.00001
Language	4	484	.85	ns
Interaction	8	968	1.42	ns
Univariate Tests for Group				
Variable	df	F	p	
Sex Roles	2,487	3.14	<.05	
Sexuality	2,487	9.10	<.0001	
Contraception	2,487	13.43	<.00001	
Abortion	2,487	2.23	<.10	

Appendix 0 continues.

Appendix O Continued.

Table 3
 Manova Results and Univariate Tests for DPI Scales
 for Matched Subsamples

Manova Tests				
Effect	df hyp	df err	F	p
Group	30	960	1.91	.005
Language	15	480	4.30	.00001
Interaction	30	960	1.08	ns
Univariate Tests for Group				
Variable	df		F	p
Insomnia	2,494		4.77	<.01
Headache proneness	2,494		1.32	ns
Broodiness	2,494		.67	ns
Depression	2,494		.49	ns
Disorganization of thinking	2,494		1.21	ns
Feelings of unreality	2,494		.23	ns
Health concerns	2,494		6.64	<.001
Hypochondriasis	2,494		4.86	<.01
Impulsivity	2,494		2.53	<.10
Mood fluctuation	2,494		.28	ns
Neurotic disorganization	2,494		.12	ns
Panic reaction	2,494		3.08	<.05
Perceptual distortion	2,494		1.17	ns
Self depreciation	2,494		.18	ns
Somatic complaints	2,494		3.97	<.05

Table 3 continues.

Table 3 continued.

Univariate Tests for Language

Variable	df	F	p
Insomnia	1,494	3.11	<.10
Headache proneness	1,494	.07	ns
Broodiness	1,494	12.63	.0005
Depression	1,494	.57	ns
Disorganization of thinking	1,494	11.30	.001
Feelings of unreality	1,494	30.14	.00001
Health concerns	1,494	.48	ns
Hypochondriasis	1,494	18.09	.00005
Impulsivity	1,494	5.70	.05
Mood fluctuation	1,494	.26	ns
Neurotic disorganization	1,494	2.21	ns
Panic reaction	1,494	8.73	.005
Perceptual distortion	1,494	27.75	.00001
Self depreciation	1,494	6.34	.01
Somatic complaints	1,494	3.41	.10

Appendix P
 Within and Between Correlation Coefficients for Attitude Measures,
 IE, DPI, and Relationship Variables

Table 1
 Within and Between Correlation Coefficients for Attitude Measures

<u>Attitudes</u>	<u>Sex Roles</u>	<u>Sexuality</u>	<u>Contraception</u>	<u>Abortion</u>
Sex Roles				
Sexuality	.56			
Contraception	.48	.59		
Abortion	.43	.48	.59	
<u>IE</u>	.12	.05	.03	.04
Rotter	.03	-.03	-.03	-.04
Mirels				

Table 1 continues.

Table 1 continued.

	<u>Sex Roles</u>	<u>Sexuality</u>	<u>Contraception</u>	<u>Abortion</u>
<u>DPI</u>				
Insomnia	-.24	-.16	-.12	-.09
Headache proneness	-.19	-.12	-.12	-.08
Broodiness	-.27	-.22	-.22	-.13
Depression	-.23	-.16	-.14	-.12
Disorganization of thinking	-.38	-.24	-.27	-.22
Feelings of unreality	-.19	-.11	-.20	-.10
Health concerns	-.30	-.23	-.18	-.15
Hypochondriasis	-.20	-.17	-.20	-.12
Impulsivity	-.01	.05	-.04	.05
Mood fluctuation	-.01	.03	-.01	.01
Neurotic disorganization	-.07	-.03	-.10	-.01
Panic reaction	-.26	-.20	-.18	-.14
Perceptual distortion	-.16	-.09	-.15	-.17
Self depreciation	-.32	-.25	-.26	-.22
Somatic complaints	-.16	-.10	-.12	-.08
Relationship Variables				
Length	-.09	-.10	-.10	-.01
Quality	.07	.02	-.03	-.02

Appendix P continues.

Appendix P continued.

Table 2
 Within and Between Correlation Coefficients for IE Scales

<u>IE</u>	<u>Rotter</u>	<u>Mirels</u>
Rotter		
Mirels	.78	
<u>Attitude Scales</u>		
Sex Roles	.12	.03
Sexuality	.05	-.03
Contraception	.03	-.03
Abortion	.04	-.04
<u>DPI</u>		
Insomnia	-.11	-.06
Headache proneness	-.14	-.09
Broodiness	-.21	-.14
Depression	-.19	-.17
Disorganization of thinking	-.23	-.18
Feelings of unreality	-.24	-.22
Health concerns	-.09	-.07
Hypochondriasis	-.17	-.14
Impulsivity	-.16	-.13
Mood fluctuation	-.23	-.19
Neurotic disorganization	-.20	-.16
Panic reaction	-.22	-.14
Perceptual distortion	-.08	-.11
Self depreciation	-.15	-.12
Somatic complaints	-.22	-.20
<u>Relationship Variables</u>		
Length	.07	.06
Quality	.11	.09

Appendix P continues.

Appendix P continued.

Table 3

Within and Between Correlation Coefficients for DPI Scales

DPI	INS	HPR	BRD	DEP	DTH	FUN	HCN	HYP	IMP	MDF	NDS	PNR	PCD	SDP	SMC
Insomnia															
Headache proneness	.35														
Broodiness	.34	.30													
Depression	.37	.32	.48												
Disorganization of thinking	.38	.37	.55	.57											
Feelings of unreality	.27	.26	.50	.46	.60										
Health concerns	.14	.16	.23	.02	.18	.18									
Hypochondriasis	.35	.44	.38	.34	.51	.48	.27								
Impulsivity	.16	.18	.29	.23	.39	.35	-.14	.28							
Mood fluctuation	.26	.23	.41	.38	.42	.46	.13	.30	.44						
Neurotic disorganization	.21	.22	.38	.30	.47	.44	-.02	.31	.57	.41					
Panic reaction	.33	.31	.52	.48	.58	.49	.23	.41	.24	.46	.34				
Perceptual distortion	.16	.08	.21	.06	.27	.41	.32	.28	.15	.22	.21	.23			
Self depreciation	.31	.29	.47	.58	.57	.42	.06	.39	.36	.28	.37	.40	.06		
Somatic complaints	.38	.44	.38	.37	.51	.41	.26	.68	.27	.38	.35	.43	.19	.36	

Table 3 continues.

Table 3 continued.

<u>Attitudes</u>	INS	HPR	BRD	DEP	DTH	FUN	HCN	HYP	IMP	MDF	NDS	PNR	PCD	SDP	SMC
Sex Roles	-.24	-.19	-.27	-.23	-.38	-.19	-.30	-.20	-.01	-.01	-.07	-.26	-.16	-.32	-.16
Sexuality	-.16	-.12	-.22	-.16	-.24	-.11	-.23	-.17	.05	.03	-.03	-.20	-.09	-.25	-.10
Contraception	-.12	-.12	-.22	-.14	-.27	-.20	-.18	-.20	-.04	-.01	-.10	-.13	-.15	-.26	-.12
Abortion	-.09	-.08	-.13	-.12	-.22	-.10	-.15	-.12	.05	.01	-.01	-.14	-.17	-.22	-.08
<u>IE Scales</u>															
Rotter	-.11	-.14	-.21	-.19	-.23	-.24	-.09	-.17	-.16	-.23	-.20	-.22	-.08	-.15	-.22
Mirels	-.06	-.09	-.14	-.17	-.18	-.22	-.07	-.14	-.13	-.19	-.16	-.14	-.11	-.12	-.20
<u>Relationship Variables</u>															
Length	-.02	-.02	-.05	-.05	-.02	-.09	-.06	-.02	-.15	-.13	-.08	.03	-.06	-.04	-.06
Quality	-.08	-.16	-.13	-.33	-.18	-.16	.08	-.15	-.11	-.20	-.10	-.11	.01	-.12	-.12

Appendix P continues.

Table 4
 Within and Between Correlation Coefficients
 for Relationship Variables

<u>Relationship Variables</u>	<u>Length</u>	<u>Quality</u>
Length		
Quality	.14	
<u>Attitudes</u>		
Sex roles	-.09	.07
Sexuality	-.10	.02
Contraception	-.10	-.03
Abortion	-.01	-.02
<u>IE Scales</u>		
Rotter	.07	.11
Mirels	.06	.09
<u>DPI</u>		
Insomnia	-.02	-.08
Headache proneness	-.02	-.16
Broodiness	-.05	-.13
Depression	-.05	-.33
Disorganization of thinking	-.02	-.18
Feelings of unreality	-.09	-.16
Health concerns	-.06	.08
Hypochondriasis	-.02	-.15
Impulsivity	-.15	-.11
Mood fluctuation	-.13	-.20
Neurotic disorganization	-.08	-.10
Panic reaction	.03	-.11
Perceptual distortion	-.06	.01
Self depreciation	-.04	-.12
Somatic complaints	-.06	-.12

Appendix Q
Means and Standard Deviations for the Attitude Measures

Group	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
Language						
N=	51	42	147	202	42	66
Séx roles	M	15.43	15.52	14.99	16.45	17.00
	SD	4.0	3.0	3.4	2.6	2.5
Sexuality	M	57.26	55.33	55.66	60.19	60.83
	SD	7.2	6.7	7.2	6.0	6.2
Contraception	M	102.55	99.48	100.09	109.98	109.00
	SD	11.5	11.5	12.5	8.7	8.7
Abortion	M	113.20	105.41	108.00	107.95	108.17
	SD	13.5	13.3	12.0	13.7	14.6

Appendix R

Means and Standard Deviations for the IE Measures

Group	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
N=	50	42	146	202	43	66
Rotter	M 12.98	12.17	12.82	12.17	12.07	11.85
	SD 3.7	4.2	4.1	3.6	3.9	3.7
Mirels	M 5.72	5.81	5.80	5.63	5.42	5.21
	SD 1.7	2.0	2.0	2.1	1.8	2.0

Appendix S
 Demographic Variables of the Abortion Patients Who Completed the KCDT
 before Contraceptive Counselling and IUD Patients who
 Completed the KCDT Prior to Seeing Physician

Group	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
Language						
N=	12	19	52	65	9	41
Age	<u>M</u>	27.67	21.87	24.25	25.67	22.78
	<u>SD</u>	5.9	4.8	5.7	6.9	3.7
Education	<u>M</u>	12.75	12.37	12.69	14.78	15.32
	<u>SD</u>	4.6	2.2	2.5	1.4	2.6
Religious	<u>M</u>	3.17	2.48	2.57	2.11	1.88
Intensity	<u>SD</u>	1.0	1.1	1.4	1.3	1.2
Number of	<u>M</u>	.92	.31	.66	.44	.10
Children	<u>SD</u>	.8	.9	1.4	1.0	.4

Appendix S continues.

Appendix S continued.

Group	Repeaters		Initials		IUD Patients*	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
Language						
N=	12	19	52	65	9	41
Marital Status						
Married	58%	16%	23%	23%	22%	12%
Not married	42%	84%	77%	77%	78%	58%
Occupational Status on Blishen Scale						
Middle	25%	32%	25%	29%	11%	20%
Working	25%	26%	25%	31%	33%	27%
Unemployed*	50%	42%	50%	40%	56%	53%

*This category also includes students and housewives.

Appendix T

Correlation Coefficients for KCDT Scores and
Demographic Variables of Abortion Patients who
Completed the KCDT before Contraceptive Counselling
and IUD Patients who Completed the KCDT Prior to
Seeing Physician (N=198)

Variable	<u>r</u>	<u>p</u>
Age	.14	<.05
Education	.52	<.001
Religious Intensity	-.20	<.005
Number of Children	-.12	<.05
Marital Status	.25	<.005

Appendix U
Demographic Variables of The Abortion Subjects
Who Completed the KCDT Both Before and After
Contraceptive Counselling (N=137)

Group	Repeaters		Initial	
	Anglophone	Francophone	Anglophone	Francophone
Language				
N	10	19	43	65
Age				
<u>X</u>	27.30	27.26	22.16	24.25
<u>SD</u>	6.4	5.9	5.0	5.7
Years of Education				
<u>X</u>	11.80	12.53	12.44	12.69
<u>SD</u>	3.2	2.6	2.2	2.5
Religious Intensity				
<u>X</u>	3.10	2.32	2.49	2.57
<u>SD</u>	1.1	1.3	1.1	1.4
Number of Children				
<u>X</u>	.80	.74	.21	.66
<u>SD</u>	.8	1.2	.6	1.4
Marital Status				
Married	60%	16%	23%	22%
Not Married	40%	84%	77%	78%
Occupation Status on Blishen Scale				
Middle Class	20%	32%	27%	29%
Working Class	30%	26%	26%	31%
Unemployed*	50%	42%	47%	40%

* This category also contains students and housewives.

Appendix V
Means and Standard Deviations for Before and After
KCDTS

Group	Language	Repeaters		Initial	
		Anglophone	Francophone	Anglophone	Francophone
	<u>N</u>	10	19	43	65
Before KCDT	<u>X</u>	7.0	8.53	8.09	7.03
	<u>SD</u>	3.2	3.3	3.7	3.3
After KCDT	<u>X</u>	7.70	9.58	9.56	7.68
	<u>SD</u>	4.0	3.2	4.0	3.7

Appendix W

Means and Standard Deviations for the DPI Scores

Group	Repeaters		Initials		IUD Patients		
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone	
N=	51	44	147	206	43	66	
Physical Complaints	Insomnia	M 3.27 SD 2.4	M 3.82 SD 2.4	M 2.90 SD 2.2	M 3.38 SD 2.2	M 2.44 SD 2.0	M 2.36 SD 2.0
	Headache proneness	M 2.24 SD 2.5	M 1.61 SD 2.0	M 1.89 SD 2.2	M 2.00 SD 2.3	M 1.12 SD 1.3	M 1.50 SD 2.2
Health concerns	M 7.02 SD 3.6	M 7.59 SD 3.1	M 7.31 SD 3.1	M 7.66 SD 2.7	M 5.84 SD 3.1	M 5.98 SD 2.9	
	Hypochondriasis	M 2.67 SD 2.3	M 3.80 SD 2.5	M 2.95 SD 2.7	M 4.02 SD 2.4	M 2.16 SD 1.9	M 2.50 SD 2.3
Somatic complaints	M 4.33 SD 2.8	M 4.64 SD 3.3	M 4.01 SD 3.0	M 4.53 SD 2.7	M 2.81 SD 2.1	M 3.33 SD 2.0	

Appendix W continues.

Appendix W continued.

Group	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
Language	51	44	147	206	43	66
Affective Adjustment						
Broodiness	<u>M</u> 3.88	5.14	4.55	5.32	3.81	4.85
	<u>SD</u> 2.6	3.2	3.2	2.3	2.1	2.4
Depression	<u>M</u> 2.35	3.20	2.71	2.68	1.95	2.03
	<u>SD</u> 3.3	3.4	3.4	3.2	2.8	2.4
Self	<u>M</u> .09	1.66	1.13	1.49	1.07	1.00
depreciation	<u>SD</u> 1.3	1.6	1.8	1.7	1.7	1.0

Appendix W continues.

Appendix W continued.

Group Language	Repeaters		Initials		IUD Patients	
	Anglophone N=	Francophone 44	Anglophone 147	Francophone 206	Anglophone 43	Francophone 66
Cognitive Functioning						
Disorganization of thinking	M 2.18	3.11	2.16	2.89	1.44	1.89
	SD 2.9	2.7	2.6	2.8	1.3	2.7
Feelings of unreality	M 2.86	4.36	3.03	4.33	2.77	3.79
	SD 2.8	2.6	2.8	2.9	2.1	2.7
Impulsivity	M 5.53	6.32	5.18	5.90	5.84	6.11
	SD 3.1	3.1	3.3	2.9	3.2	3.2
Mood fluctuation	M 7.84	8.36	8.43	8.45	7.74	8.88
	SD 3.0	3.1	3.3	2.9	3.0	3.1
Neurotic disorganization	M 4.02	4.82	4.29	4.76	4.42	4.26
	SD 3.0	3.1	3.5	3.4	3.1	3.2
Panic reaction	M 4.65	5.43	5.12	6.00	3.91	4.89
	SD 3.0	3.1	3.6	3.1	2.8	3.1
Perceptual distortion	M 3.33	4.80	3.74	5.15	3.47	3.74
	SD 2.4	2.5	2.5	2.4	2.6	2.6

Appendix X
Means and Standard Deviations for the Relationship Variables

Group Language	Repeaters		Initials		IUD Patients	
	Anglophone	Francophone	Anglophone	Francophone	Anglophone	Francophone
N=	51	44	147	203	39	60
Length of relationship	M 35.45	47.25	34.03	39.84	47.36	29.68
	SD 57.1	65.5	43.6	49.4	49.8	28.9
Quality of relationship*	M 3.77	3.64	3.95	4.17	4.18	4.42
	SD 1.1	1.0	.9	.9	.8	.8

*A higher score reflects a more positive relationship.

Appendix Y

Statistical Analyses for Attitude Measures for Repeat and Initial Abortion Patients as a Function of Group, Language and Contracepting

Table 1

Manova Results and Univariate Tests for Attitude Measures as a Function of Group, Language, and Contraception Category

Manova Tests				
Effect	df hyp	df err	F	p
Group(G)	4	431	4.20	<.005
Language (L)	4	431	1.44	ns
Contracepting (C)	4	431	4.12	<.005
G x L	4	431	1.71	ns
G x C	4	431	.15	ns
L x C	4	431	1.44	ns
G x C x L	4	431	3.65	<.05
Univariate Tests for Group				
Variable	df	F	p	
Sex Roles	1,434	.90	ns	
Sexuality	1,434	2.15	ns	
Contraception	1,434	4.20	<.05	
Abortion	1,434	15.86	<.0001	
Univariate Tests for Contracepting				
Variable	df	F	p	
Sex Roles	1,434	.78	ns	
Sexuality	1,434	1.89	ns	
Contraception	1,434	13.61	<.0005	
Abortion	1,434	7.97	<.005	
Univariate Tests for G x L x C				
Variable	df	F	p	
Sex Roles	1,434	.51	ns	
Sexuality	1,434	2.17	ns	
Contraception	1,434	.64	ns	
Abortion	1,434	6.02	<.05	

Appendix Y continues.

Appendix Y continued.

Table 2
Means and Standard Deviations for Attitude Measures for Contracepting (C) and Noncontracepting (NC), Initial and Repeat Abortion Patients

Group	Repeaters						Initials											
	Anglophone		Francophone		Anglophone		Francophone		Anglophone		Francophone							
	NC	C	NC	C	NC	C	NC	C	NC	C	NC	C						
N=	23	28	19	23	86	61	101	101	101	101	101	101						
Sex Roles	M	15.04	15.75	16.00	15.56	15.37	15.74	14.82	15.16	SD	3.9	4.0	2.2	3.5	3.2	2.8	3.2	3.6
Sexuality	M	58.65	56.11	54.26	57.61	55.11	55.66	54.90	56.43	SD	7.3	7.0	6.9	7.8	6.6	6.9	6.8	7.6
Contraception	M	101.13	103.71	99.95	105.13	98.09	101.44	97.66	102.53	SD	11.2	11.7	11.2	10.4	10.7	12.3	11.8	12.9
Abortion	M	115.65	111.18	106.74	117.00	103.93	107.49	106.22	109.78	SD	11.7	14.7	17.2	10.5	11.2	15.6	11.4	12.4