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ATTITUDES TOWARD PREGNANCY REGULATION
IN A GENERAL POPULATION SAMPLE

A Dissertation
Presented for the
Doctor of Philosophy
Degree
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Judy Vaughan Plummer

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Dedicated to Ken

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ABSTRACT

The prolonged and vociferous debate over a pregnant woman's right to abortion has been accompanied by frequent media reports of public attitudes. Recently, other legal rights of pregnant women have been denied or abridged, e.g., selection of medical treatment. Some groups, such as the American Civil Liberties Union, have opposed such restrictions, pregnancy regulation; however, these restrictions have not been the subject of widespread debate nor is much known about public attitudes on the topic.

Both abortion restriction and pregnancy regulation raise questions about a woman's right to control her own body or reproductive freedom. Comparison of public attitudes toward both topics provides an opportunity to explore whether the same general beliefs underlie attitudes toward these related topics. Schema theory developed by attitude theorists suggests that attitudes toward related topics may be based in the same schema or cognitive structure. Such cognitive structures direct individuals' perceptions and interpretations. If a common schema underlies attitudes toward abortion restriction and

pregnancy regulation, public attitudes toward the two topics presumably would be distributed similarly.

This study addressed three questions: (a) whether the distributions of public attitudes toward abortion restriction and pregnancy regulation were similar; (b) what beliefs and social characteristics were determinants of both types of reproductive attitudes; and (c) whether a common schema appeared to underlie abortion and pregnancy regulation attitudes.

Opinion questions from previous studies of abortion and pregnancy regulation attitudes were incorporated in a questionnaire. Questions about basic beliefs on individual rights, family rights and children's rights were included as one way to ascertain cognitive structure. And, questions about attitudes (e.g., religiosity) and social characteristics (e.g., education level) often correlated with abortion attitudes were included to explore for common determinants of attitudes toward pregnancy regulation and abortion.

A general population sample was randomly drawn from the Knoxville City directory. The questionnaire was administered to 201 adults over the telephone. The sample collected was reasonably representative of the Knoxville population.

The sample was more supportive of a woman's right to

abortion than of a pregnant woman's right to control her own body. The attitudes toward abortion rights were more conservative than national attitudes, but comparable to those reported in polls of Southeastern residents of the United States.

For both abortion and pregnancy regulation attitudes, multiple regression models were developed. The model which best fit attitudes toward abortion choice was consistent with an individual rights schema. On the other hand, the model which best fit attitudes against pregnancy regulation was based on gender and beliefs about medical control.

Currently, the public does not appear to perceive both abortion and pregnancy regulation as issues of individual (woman's) rights. If pregnancy regulation becomes the focus of widespread debate, organized groups and/or the mass media may sharpen and direct perceptions to the individual rights issues involved in pregnancy regulation.

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CHAPTER I

INTRODUCTION

Abortion long has been the subject of debate. In recent decades the public debate increasingly has juxtaposed the rights of women to control their reproductive choices and the rights of the unborn to life.

The abortion debate has been conducted with both pro choice and pro life advocates attempting to argue that their position reflects basic rights which need to be protected. Investigation of another reproductive issue which has not been the subject of such prolonged, bitter debate provided an opportunity to ascertain if attitudes toward reproductive issues have a common base, that is, if they reflect a common core of beliefs.

Conflict between the rights of a pregnant woman and the rights of the unborn exists in court decisions and legislative actions which restrict or punish women who continue their pregnancies. In recent instances the courts have "stepped in" to control the mother-to-be's behavior during pregnancy or delivery. In other cases, courts have punished women for engaging in prenatal behavior that apparently resulted in damage to their children. In both situations, the court has considered

the fetus to have rights which are separate from the rights of the childbearer.

A survey in Glamour (1988) magazine found readers of the magazine approved of greater social control of pregnant women. A study of doctors working in maternal-fetal medical programs reported a substantial number believed pregnant women should be forced to comply with "doctor's orders" (Kolder, Gallagher and Parsons, 1987). A twelve state poll conducted by The Atlanta Journal Constitution found a majority supported criminal prosecution of a mother whose prenatal behavior led to the birth of a damaged or drug dependent infant (Hansen, 1989).

Although limited information exists about public attitudes toward pregnancy regulation, none exists about the relationship between attitudes toward pregnancy regulation and attitudes toward abortion. Attitudes toward pregnancy regulation and abortion could be similar, if they reflect the same basic set of underlying beliefs about the rights of the individual, the rights of the family and the rights of children. Attitude schema theory provided the framework with which attitude consistency was explored.

The importance attached to various types of rights potentially affect attitudes toward abortion and pregnancy regulation. The rights of the individual, particularly

the right of privacy; the rights of the family, particularly spousal and parental rights; and the rights of children as represented by the state are three of interest.

Various groups have tried to influence the courts and/or legislators to restrict the rights of the individual. State intervention in the personal lives of its citizens via the legal system range from matters of individual sexual behavior (sodomy laws, pornography regulations) to family interaction (child abuse and neglect statutes, marital rape laws.)

Individual rights, particularly the right of privacy, are invoked by those who argue against court interference with reproduction. One precedent often cited is Carey v. Population Services International (1977) which states "The Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."

Those who argue for family rights refer to concern for the potential child. Some who favor greater control of pregnant women's behavior refer to the social cost of caring for defective or drug dependent newborns.

This study explored social attitudes by surveying a sample of the general population. The focus of the survey was attitudes toward social control of women during pregnancy. Included in issues of social control were attitudes toward abortion and attitudes toward pregnancy

regulation. This research investigated the consistency of attitudes toward pregnancy regulation and abortion, as well as the similarity of the belief structures underlying those attitudes.

CHAPTER II

ORIENTATIONS TOWARD RIGHTS

In the United States several types of rights are recognized and the legislative and judicial branches of government have established which rights take precedence in various circumstances. Members of the public may disagree with laws and court decisions and lobby for change. When disputes occur, public debates often involve people on each side of an issue invoking arguments about the priority of one set of right over another. In these public debates the rights debated are ideal types.

People have different conceptions of what set of rights should be preeminent, particularly in matters of reproduction. Some people believe reproductive decisions are primarily a family concern; others treat them as a matter of individual rights. Yet, others express concern for the child and argue government should have control as protector of potential life. These differing orientations may play a role in shaping attitudes toward abortion. They may also underlie attitudes toward control of women's prenatal behavior.

People recognize the salience of each type of right in different circumstances. For example, the right of the

family is preeminent when parents are deciding what, if any, religious training their children will receive. The right of the individual (verbalized by the U.S. Supreme Court as the right of privacy) is generally accepted as the standard for private sexual behavior between consenting adults. Children's rights may be viewed as separate from family rights (when the family does not provide necessary care for children) or individual rights (when young children can not care for themselves). Whenever children's rights become a separate issue, the state government's right to establish rules to protect children becomes preeminent.

Debates apparently occur at the points where issues overlap and each issue is seen as the object of a different right or when the right is invoked in a different manner. In Roe v. Wade (1973), the U.S. Supreme Court ruled abortion was fundamental and should be governed by the right of privacy up to the time of viability. Advocates of family rights challenge the right of the pregnant woman to have an abortion without the consent of her husband or without her parents' permission if she is underage. Various states have claimed the fetus is a human being and the government has a responsibility to protect the right of the fetus ("unborn child or baby") by prohibiting abortion.

This chapter explores the relationship between these orientations (family rights, individual rights, children's rights), pregnancy and abortion. The rights orientations represent ideal types.

Family Rights Orientation

The family rights orientation emphasizes the autonomy of the family. The exercise of family autonomy sometimes clashes with the legal system even though the traditional family form is the pattern most clearly supported by legal authority (Macklin, 1987). Laws limit the rights and establish the responsibilities of the family unit. Controversies which erupt over the family's right to regulate matters such as the education of children and member reproduction and the court's right to place limits on family control often have religious overtones. Families often draw on religious beliefs to shape and justify their actions, which may be incompatible with legal separation of church and State.

Education of Children

As early as 1923 the U.S. Supreme Court found an "implied" right in the U.S. Constitution for parents "to control the education of their own" (Meyer v. Nebraska, 1923). Family rights in educational decisions were

reaffirmed in 1925, when the Supreme Court struck down an Oregon law which required all children to attend public schools (Pierce v. Society of Sisters, 1925). The right of parents to educate their children in accordance with their religious beliefs was upheld in Wisconsin v. Yoder (1972). The result of these challenges to State controlled education has been an onslaught of alternative educational choices, private schools (often church affiliated) that disseminate traditional familial and religious values (Settles, 1987).

A good deal of the controversy between parents and public school systems seems to center around sexuality. Advocates of family rights favor parental control of school curricula, particularly in restricting information about birth control and sexual relationships. Parents are believed to be the best source of information on moral issues. Family rights advocates argue that public school sex education undermines the family's control over offspring and encourages liberal and undesirable behavior.

Reproduction

A traditional function of the family is to control reproduction of its members. With advances in biology and medicine family control expanded to include birth control and abortion. Prior to Roe v. Wade (1973) traditional family interests on issues of birth control and abortion

were often upheld by state laws. Many of these state laws were declared unconstitutional by the U.S. Supreme Court (Goldstein, 1979).

A number of states prohibited the use of contraceptives until the mid 1960s. Bans on contraceptives were consistent with religious teachings about the "duties" of married couples to bear and raise children. In 1965 a Connecticut law that made it illegal for any person, including married couples, to "use any drug, medicinal article or instrument for the purpose of preventing conception" (Griswold v. Connecticut) was challenged. The majority opinion in Griswold v. Connecticut later played an important part in the abortion decisions of the 1970s. Justice Douglas wrote

Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship (Griswold v. Connecticut 381 U.S. 479, 1965).

The Connecticut contraceptive law was ruled unconstitutional because it intruded on the husband-wife relationship.

In the same decision, the court upheld the autonomy of the family by indicating that the state might legitimately suppress extramarital sexual activity (Goldstein, 1979). Unmarried individuals purchasing or using contraceptives were still breaking the law.

In 1972 the right of single individuals to procure contraceptives was established by the U.S. Supreme Court. The decision in Eisenstadt v. Baird (1972) was a victory for advocates of individual rights but far from welcome to those who believed in the traditional family. For traditionalists sex is sacred to matrimony and its primary purpose is reproduction. When the courts extended the right to purchase and use contraceptives to unmarried individuals, they legally redefined sex as a secular activity.

The reasoning of the Eisenstadt decision was reaffirmed in 1977 (Carey v. Population Services International) when the U.S. Supreme Court decided unmarried minors under sixteen had a right to obtain contraceptives (Goldstein, 1979). Although minors under eighteen needed parental consent for most medical treatment, they could be treated for venereal diseases, purchase contraceptives or obtain an abortion (in some instances) without the consent of their parents.

Proponents of family rights see the courts as infringing on the autonomy of the family in the areas of procreation and sexuality by affirming individual rights in some cases and establishing government control in others. Parents are believed to be the best source of information about sex and the guardians of pre-marital sexual behavior. State government, by providing sex

education in the schools and supporting the legal availability of contraceptives to minors, is in their view encouraging children to engage in behaviors opposed by their parents and detrimental to society as a whole.

Abortion

Family rights advocates may oppose abortion on moral or religious grounds but they also consider abortion a family matter. The right of choice on the abortion issue should belong to the head of the family, the husband. The husband should be consulted if his wife is seeking an abortion. As head of the family and father of the potential child, he should be able to prevent her from getting an abortion. In some instances, such as a pregnancy resulting from rape, family rights advocates may approve of abortion because rape violates family autonomy. Maintaining the family unit intact is the primary consideration. Although the family rights orientation would not preclude abortion, it would preclude the woman's freedom to choose independently (Conover and Gray, 1983).

Legislation that allows minors to seek an abortion without parental permission is in opposition to the family rights position. Abortion for minors, sex education and access to contraceptives, are viewed as family issues rather than individual rights or government matters. State laws generally require that parents be notified if

their daughter who is a minor seeks an abortion but to date the U.S. Supreme Court has denied the parents veto power over their daughters' decisions (Gelb and Palley, 1987).

Individual Rights Orientation

An individual rights orientation is based on a belief in the "inalienable rights" of the individual insured by the U.S. Constitution. The rights of the individual are assumed to outweigh those of the family by people who hold an individual rights view of the role of the state government (Liss, 1987). Medical advances and the civil rights movements have focused attention on individual rights issues during recent years.

Advances in medical knowledge and technology have forced choices that would not have been an issue a few years ago. Babies suffering from severe birth defects may be "saved" by modern medical miracles; dying people may be kept alive almost indefinitely by machines; and reproduction of human beings may begin in test tubes. An individual rights orientation supports free choice of the individual whether it is in matters of reproduction or the right to refuse medical treatment (Liss, 1987).

An individual's right to refuse medical treatment has been upheld by the courts in some instances

(institutionalized mental patients cannot be medicated against their wills and incompetents cannot be forced to undergo medical treatments), but in other instances, courts have ordered medical treatments or procedures over the objections of individuals. Most cases of forced treatment deal with intervention in pregnancies (Gallagher, 1987).

The courts seem to be in a quandary on the issue of individual rights when the individual is pregnant. At the state level, courts have ordered pregnant women to undergo medical tests, blood transfusions, medical treatment, hospital confinements and Cesarean deliveries against their will. These decisions seldom stand up to appeal to a higher court (Gallagher, 1987) but a few of the decisions have been the focus of concern for proponents of individual rights, particularly feminists.

In one instance, a twenty eight year old woman suffered a recurrence of a cancer that had been in remission for over two years. She was pregnant and the court took away her individual right to refuse medical intervention. The cancer was diagnosed as terminal during the twenty sixth week of pregnancy. The court ordered her fetus delivered by Cesarean section over the objections of her doctor and family. When told of the decision, the woman told her doctor, "I don't want it done." An appeal was denied and the surgery performed. Both mother and

child died, the child shortly after birth and the mother two days later (Annas, 1988).

Another area where individual rights collide with state court decisions is in the area of religion, particularly the intersection of medicine and religion. The courts usually allow adults to refuse medical treatment for religious reasons (even when the lack of treatment may result in death), but religious reasons are not viewed as sufficient cause for a pregnant woman to refuse medical care. Medical authorities routinely look to the courts to "order" blood transfusions for Rh negative infants whose parents oppose medical intervention. And courts have in several instances ordered Cesarean deliveries over women's religious objections (Nelson and Milliken, 1988). In one instance, a hospital petitioned a court to issue an order authorizing a Cesarean section and any necessary blood transfusions on a woman "in case" she came to the hospital for the delivery of her child. The woman had been to the hospital for prenatal care and had been advised that a condition of placenta preavia would require surgical delivery of her fetus. The patient refused surgical intervention for religious reasons. The court refused the hospital's request but suggested that some state agency intervene. The state social services agency petitioned for and received "custody" of the fetus. The agency was

given full authority to make decisions regarding the fetus, including consent for a surgical delivery. The woman was ordered to acquiesce to the doctor's and agency's decisions (Jefferson v. Griffin Spalding County Hospital Authority, 1981).

The willingness of the courts to intervene in the lives of pregnant women at the request of medical authorities has given rise to the issue of pregnancy regulation. The pregnancy regulation controversy, discussed at length in legal commentaries (Rhoden, 1986; Gallagher, 1987; Fortin 1988) and occasionally in medical publications (Bowes and Selgestad, 1981; Landwirth, 1987), appears to be paralleling the abortion controversy. Feminists and civil libertarians support a pro-choice type position (that is, that women should be free to make any and all decisions that relate to reproductive control of their bodies). Freedom of choice includes the right to make decisions about behavior during pregnancy and medical choices during pregnancy and at delivery. The American Civil Liberties Union has adopted the role of "watchdog" of individual rights through their Reproductive Freedom Project. Others support a pro-life type position that every fetus is a "child," that the courts should protect the fetus by controlling the mother. If prenatal behavior might adversely affect the fetus, that behavior should be stopped, by force if necessary.

The medical community knows more than ever about the connection between maternal behavior and fetal well being. Yet, much uncertainty remains in modern day medicine. The general public is even less sure of what maternal behaviors might result in harm to the fetus. When the court intervenes on behalf of the fetus, medical judgement is used as the basis for restricting or ignoring the individual rights of the pregnant woman.

The differences between the attitudes of pro-choice and pro-life activists on the issue of individual rights have been identified by researchers. Kristin Luker argued of pro-choice advocates that "a staunch belief in the rights of the individual led them to believe that only individuals, not governments or churches, can ultimately make ethical decisions" (1984:184). Abortion opponents expressed a world view in opposition to individual rights (Luker, 1984). A pregnancy (whether planned or unplanned, the result of marital intercourse or rape) was God's will. The individual woman had no rights; interference in God's plan was morally wrong. Therefore, there was no justification for abortion.

People whose view is consistent with an individual rights orientation support the right of the woman to choose to have an abortion and oppose others' efforts to impose their will on the individual in any circumstance.

Children's Rights Orientation

As a general rule, concerns about children are a variant of a family rights orientation. Concern for children may evolve into an issue of State's rights when families fail to provide the care and protection children need. The Children's Rights Movement of the 1960s and 1970s resulted in a greater social awareness and expanded definitions of abuse and neglect (Gross and Gross, 1977). Child abuse and neglect laws are the outgrowth of heightened concerns for the well-being of children.

State agents such as the court system uphold parents' rights in most instances. State government reserves the right to intervene when parental actions or decisions jeopardize the health or safety of the child, e.g. from parents' decisions to withhold medical treatment for religious reasons or to withhold lifesaving treatment from newborns with severe birth defects.

Current controversies in children's rights focus on the legal status of the fetus. Two major arguments appear in the debate over the status of the fetus. The first argument relies on legal precedent for recognition of the fetus as a person. Since laws protect children from undue harm (even at the hands of their parents), personhood for the fetus should extend equal protection to the unborn.

The second argument is the individual states' rights to protect the "potentiality of life" based on the U.S. Supreme Court decision in Roe v. Wade (1973).

The Fetus as a Person

Early law recognized the fetus as having the right to inherit in certain circumstances. The fetus was not a "person" in any other legal situation. Until the 1940s any effort to recover for damages to a fetus were dismissed as outside the meaning of the law. In Bonbrest v. Katz (1946), the U.S. Supreme Court allowed recovery to an infant for injuries suffered before birth. This decision produced a major turn around in civil law philosophy, but most subsequent suits were against third parties and compensated both child and parents. Over time, the right of the child to sue for neo-natal injuries has been recognized in a broader range of circumstances (Morrison, 1979). In the 1980s courts have allowed civil suits by children against their mothers for acts resulting in neo-natal damage. For example, one mother had taken tetracycline during pregnancy resulting in permanently discolored teeth for her son. The child successfully recovered damages for his mother's prenatal behavior (Carroll, 1986).

Legal professionals supporting the fetal rights position suggest the increased liability of parents in

civil suits indicates a broader concern for a child's right to be born healthy and undamaged. While many factors play a part in the well-being of newborns, fetal rights advocates are particularly interested in maternal behaviors. Few commentaries mention a father's responsibility to the fetus (Blank, 1986), but many suggest the need for greater restraints on maternal behavior (Shaw, 1984; Reece and Reece, 1985; Stearns, 1986; Carroll, 1986; Robertson and Schulman, 1987).

State's Rights On Behalf of Children

The Roe v. Wade (1973) decision of the U.S. Supreme Court which upheld women's right to seek an abortion is ironically often cited as precedent for State intervention in the life of the pregnant woman who does not chose to have an abortion. Fetal rights advocates refer to the following passage:

With respect to the State's important and legitimate interest in potential life, the "compelling" point is at viability (Roe v. Wade 410 U.S. 113, 1973).

The State's interest in potential life is viewed as comparable to the State's interest in protecting the welfare of children.

Although parents have broad authority in family matters, children have certain rights to protection by the State. Child abuse and neglect statutes spell out situations where States can intervene between the parent

and child. Proponents of fetal rights often draw parallels between child abuse and fetal abuse. The power of the State to protect children within its jurisdiction is compared to the State's right to protect "potential life" (King, 1979).

Fetal Protection: Personhood for the Fetus

The Roe v. Wade (1973) decision invalidated 46 state laws criminalizing abortion and new legislation was passed by many states in response to the decision. While some states passed more liberal laws that conformed to the new constitutional requirements, other states sought measures to circumvent the effect of the ruling. Some of these state regulations focused on the fetus.

In June 1973, the New England Journal of Medicine published the results of research using aborted fetuses. The research was aimed at testing the effects of antibiotic drugs on the unborn. Antibiotics were administered to women who were to undergo abortions. The absorption of the drug by the fetus was measured after the abortion. Subsequent public outcry precipitated an investigation and the criminal indictment of several doctors involved in the abortions and the research. The four researchers were never tried. A doctor who performed one of the abortions in question was charged with

manslaughter and convicted. The conviction was reversed on appeal (Rubin, 1987).

The fear that aborted fetuses could be used for medical research led to legislation in several states forbidding such experimentation (Rubin, 1987). Other state laws required that doctors make every effort to save the life of a fetus that "survived" an abortion. Rhode Island and Louisiana passed laws declaring that the fetus was a "person" from conception, but these "personhood" statutes were declared unconstitutional by a lower federal court. Subsequently, several states passed "personhood of the fetus" laws that designated life begins at conception apparently anticipating a reversal of the Roe v. Wade (1973) decision.

Another approach to fetal protection adopted in the wake of the Roe v. Wade (1973) decision was a move by some members of the U.S. Congress to redefine the word "person" in the U.S. Constitution and the Amendments to include "unborn persons." Several of these "human life" amendments were referred to the Subcommittee of the Senate Judiciary Committee. After sixteen days of public hearings, the Committee decided the proposed amendments would encounter numerous legal and constitutional obstacles and the proposals were not pursued.

Between 1976 and 1983 in each session of the U.S. Congress "human life" amendments were discussed.

Apparently frustrated with the long process of trying to amend the U.S. Constitution, Senator Jesse Helms (R., N.C.) introduced a two part Human Life Bill in 1981 (Gelb and Palley, 1987). The first part declared that the U.S. Congress had determined that human life begins at conception; the second part attempted to restrict the federal appeals process in abortion rulings. Support for the bill was limited and the Senate took no action.

The issue of "personhood" for the fetus resurfaces frequently at the state level where referendums address the redefinition of the beginning of life as "at conception." The most recent of these was a referendum passed by the voters of Arkansas in November, 1988.

People whose attitudes reflect a fetal rights orientation define human life as beginning at conception. The apparent failure of the pregnant woman to safeguard that life, by following doctors' orders and abstaining from potentially damaging behavior, is tantamount to "abuse of a child." Abortion, to fetal rights proponents is never acceptable, even in cases of rape or serious risk to the mother's health.

The Interrelation of Orientations

Because the rights orientations represent ideal types, people may take positions which combine aspects of

two or more orientations. As a logical extension of belief in individual rights, a person might endorse fetal rights. Other beliefs may lead people to have combination orientations. A strong commitment to religion might have an affect on attitudes toward individual rights and children's rights as well (Luker, 1984). Strong belief in medicine and science may shape attitudes about the role of state government and the courts, rights of the family, individual rights and children's rights, particularly as reproduction is often viewed as a medical issue (Eakins, 1986).

The Influence of Medicine

Belief in the infallibility of the medical professional may be reflected in attitudes about the superiority of medical advice and support for state control of medically approved options (such as court orders to enforce "doctor's orders"). The effect of medical endorsement on social policy concerning abortion rights is apparent in the history of abortion regulation (Luker, 1984). Abortion and pregnancy regulation both concern reproductive issues and may be linked in the minds of the general public. The development of a medical model of reproduction is important in this study because of wide

general acceptance and potential for influencing attitudes toward pregnancy and abortion.

Early Control of Reproduction

Historical analyses of women's issues, particularly pregnancy and childbirth, document the take-over of once female arenas by the medical profession (Eakins, 1986; Anderson, 1988). Until the 19th century, birth was a female domain. Any "knowledge" of how the embryo developed was myth. Conception, pregnancy and delivery were viewed as God's plan and therefore unfathomable. Women relied on one another for assistance during births.

The feminine nature of childbirth was only one reason women were called upon to assist at births. Early healers were women who developed "folk" medicine as one of their domestic skills. Females frequently passed medical knowledge and techniques from generation to generation. Women were widely accepted as midwives, the most knowledgeable persons available in the area of childbirth.

As late as 1800, trained doctors had little to offer women undergoing birth. Bleeding was the treatment most frequently prescribed by doctors. Physicians could not accurately diagnose a pregnancy until after quickening. Physicians were satisfied to leave pregnancy and childbirth in female hands until the second half of the 19th century. By 1850, medical intervention had led to

changes in society's beliefs about both pregnancy and childbirth. Two changes were important in the ultimate medicalization of childbirth and pregnancy; women's acceptance of medical intervention and advances in medical knowledge (Eakins, 1986).

The Medicalization of Childbirth

For women medical intervention offered greater assurance of a live birth and a possible escape from the pain that accompanied childbirth. "Women no longer had to perceive the outcome of birth as solely in the hands of God" (Eakins, 1986:17). Even before the development of anesthesia European medical schools were instructing their students in the use of forceps to aid in difficult births. Once medical schools, societies and publications were established in the U.S., knowledge about the successful use of forceps for difficult labors became widespread. Other medical developments such as ether and chloroform were welcomed as relief from pain, a significant factor to women in accepting medical intervention in deliveries.

Until medicine adopted an interventionist approach to delivery, men traditionally left issues of procreation in God's hands. The pain of childbearing, common with early childbirth practices, was defined by the religious institution as atonement for woman's original sin. Women were glad to turn to doctors for reassurance that "pain

and death were not necessarily God-given outcomes" (Eakins, 1986:28).

The development of a communications network within medicine in the 19th century had important consequences for the rapid medicalization of pregnancy and childbirth. New medical knowledge in obstetrics spread rapidly after the founding of medical schools, societies and journals (Eakins, 1986). Increasing numbers of physicians trained in the new specialty of obstetrics. With a general population shift from rural to urban, more women had access to professional medical care and they gradually embraced it as safer and less painful.

The political process used by those in the medical profession to assure access to this new clientele (pregnant women) has been documented (Luker, 1984; Eakins, 1986; Schur, 1984; Anderson, 1988). In less than a hundred years, childbirth shifted from a female domain to a medical specialty.

The shifts toward medicalization of pregnancy and childbirth continued into the 20th century with the gradual transferring of the birth process from home to hospital. One quarter of all U.S. births occurred in hospitals in 1930. By 1975 hospital births exceeded 95% of all births in this country. The medical interventionist approach, originally accepted because it

alleviated pain and promised a greater likelihood of a live birth, continues to dominate maternity care.

Medical technology and knowledge about prenatal development has increased, with tremendous advances in the last half century. Pregnancy and birth are routinely defined as medical events (Anderson, 1988). The connections between maternal behavior and fetal well-being are better understood, particularly by physicians who set strict limits on what is a "normal" pregnancy. Environmental threats to the development of a healthy fetus have been identified (such as maternal infections, environmental chemicals, occupational hazards and prescription drugs). Prenatal testing can identify potential problems soon after conception. New techniques allow doctors to intervene to correct some birth defects by operating on the fetus before birth (Engelhardt, 1985).

The medicalization of pregnancy and birth may have importance for this study. Wide acceptance of the medicalization of childbirth means physicians are considered authorities on healthy prenatal maternal behavior. Beliefs about the ultimate wisdom of doctors can be seen in the ready acceptance of "doctors' orders" as the criterion for judging what's best for mother and the fetus.

Medical Involvement in the Abortion Issue

Prior to the explosion of medical knowledge and techniques in the 19th century, graduates of medical school had little to set them apart from "medicine show doctors" of the day. Regular doctors, often trained in European schools, were in unregulated competition with self proclaimed "healers." There were no guidelines for medical practice, no licensing procedures and no limitations on those who could practice medicine. When the AMA was established in 1847, the members undertook a mission to "upgrade" medicine. Medicine needed a clientele and a public image of superior knowledge and moral integrity. In 1853, the AMA passed a resolution to oppose an emerging social problem, abortion (Luker, 1984).

When Britain passed a law forbidding abortion in 1803, there were no laws pertaining to abortion in the U.S.. Some believe abortion was widely used to limit family size (Rubin, 1987; Luker, 1984). There are no available data on abortions for this era; but it has been well documented that abortion inducing drugs were routinely and openly advertised, as were "clinics" for ladies who suffered from "suppressed menses" (the variety produced by pregnancy). Religious newspapers of the day regularly carried both advertisements. The fetus was not alive until birth as far as society was concerned (Luker, 1984).

Newspaper accounts of deaths due to abortions provoked public interest in the issue. Physicians began to openly oppose abortions, arguing that they were medically dangerous and morally wrong. Medical societies investigated the "problem" of abortion while physicians associated with universities published books and articles shaping public views and urging legal sanctions (Rubin, 1987).

Physicians justified their opposition to abortion on the ground of superior knowledge; only they had scientific knowledge about when life began. Physicians were morally obligated to "protect" women from committing this crime due to lack of knowledge. Blaming women for undergoing abortions would have alienated the clientele physicians hoped to attract. While physicians may have been concerned about the moral injustice of abortion, they were more committed to establishing a medical practice. The stand adopted by the medical profession opposed abortion but gave precedence to saving the mother's life. An indication of the effectiveness of this approach was the rapid criminalization of abortion. By 1900 all states had adopted statutes outlawing abortions. Almost all state laws included therapeutic exceptions. Physicians were the only persons with legal authority to declare an abortion necessary (Rubin 1987; Luker, 1984). Some authors suggest physicians were as fervent in guarding

their right to decide when to perform abortions as they had been in limiting women's rights to these same decisions (Schur, 1984; Luker, 1984; Rubin, 1987).

Continued gains in medical knowledge about fetal development and embryology led to a "change of heart" in the medical field and physicians were in the forefront of the move to reform abortion laws that began in the mid 1900s. By this time physicians had lost a great deal of autonomy in making abortion decisions. The widespread reliance on hospitals for surgical procedures meant more people were involved in every abortion decision. To guard themselves from legal repercussions, most hospitals had therapeutic boards which ruled on the need for an abortion to "save the mother's life". Existing abortion laws were poorly suited to deal with what medical science was discovering about the effects of drugs (Thalidomide) and disease (German measles) on the fetus.

Due to the ready acceptance of childbirth as in the domain of medicine and medical personnel, a focus of the current study was to find out whether attitudes toward medical control can explain attitudes toward reproductive issues.

CHAPTER III

ATTITUDES TOWARD ABORTION

Abortion attitude research can be roughly divided into three categories based on sources of information. Social scientists have adopted two approaches: the examination of national data sets to identify correlates and the comparison of activists opposing and supporting abortion rights. In addition national polling agencies have regularly assessed attitudes toward abortion and their correlates. Examinations of abortion attitudes indicate supporters of legalized abortion differ from opponents on a number of social characteristics: religion, education, sex, age, family traditionalism, marital status, social class, occupation and political ideology (Luker, 1984; Rodman et al., 1987; Gelb and Palley, 1987; Anderson, 1988).

Religion

Religion has been consistently correlated with abortion attitudes since the mid-nineteenth century when the first U.S. anti-abortion campaign was mounted (Milbauer, 1983). The Catholic Church has been openly

involved in the opposition to legalized abortion (Conover and Gray, 1983; Rodman et al, 1987). After the Roe v. Wade (1973) decision, the Catholic Church began a drive to pass a right-to-life amendment which would effectively de-legalize abortion (Luker, 1984; Gelb and Palley, 1987). One researcher found Catholics were more likely to be actively involved in the opposition to abortion (Luker, 1984).

The Catholic Church often was considered the organized religious opposition to abortion. Recent studies of activist groups report Southern Baptist and other fundamentalist Protestant groups also hold strong anti-abortion attitudes (Gelb and Palley, 1987; Plutzer, 1988). The politics of abortion offered a common meeting ground for the Catholic Church and some right-wing fundamentalist preachers who were part of the "Moral Majority." Access to large television and radio audiences facilitated a number of fundamentalist Protestant ministers in building a large constituency of "born-again" Christians concerned with bringing about a change in public policy toward abortion (Petchesky, 1984). Radical factions of the fundamentalist anti-abortion movement (such as Operation Rescue) have adopted tactics that have made them highly visible to the public.

Among activists and the general public, the importance of religion to the individual rather than

religious affiliation is the stronger predictor of anti-abortion sentiment (Legge, 1985; Sheeran, 1987; Gelb and Palley, 1987; Plutzer, 1988).

Education

People who oppose abortion differ on social characteristics other than religiosity. In general, the less education individuals have completed, the more negative are their attitudes toward legalized abortion (Gelb and Palley, 1987). Education often interacts with other variables (such as sex or marital status) in explaining abortion attitudes among activists (Luker, 1984). Anti-abortion attitudes are particularly strong among high school educated, married females (Luker, 1984; Gelb and Palley, 1987).

Sex

Luker (1984) found that male activists differed in terms of attitudes toward abortion from female activists. No clear differences existed in social characteristics, such as education, marital status, etc., between males who supported abortion and those who opposed abortion.

Age

Age is another demographic variable some social scientists have found associated with abortion attitudes.

As age increases, so does opposition to abortion (Legge, 1985; Rodman et al, 1987).

Family Traditionalism

Age may interact with traditionalism, but many younger Americans hold traditional views of family and gender roles as well. Positive attitudes toward "glories of motherhood" a traditional view of woman's role, were consistently negatively correlated with support for abortion among activist populations (Luker, 1984; Sheeran, 1987).

Marital Status

Among activists, marital status has been correlated with women's abortion attitudes but not men's. Some studies of activists indicate divorced and previously divorced women have more favorable attitudes toward the availability of abortion (Luker, 1984; Legge, 1985; Gelb and Palley, 1987; Plutzer, 1988).

Social Class and Occupation

Social class and occupation are frequently correlated with attitudes toward abortion. Lower and working class families have more negative attitudes toward abortion, while upper middle and upper-class families were generally

more favorable in their attitudes toward abortion (Luker, 1984; Gelb and Palley, 1987; Rodman et al., 1987; Anderson, 1988).

Political Ideologies

Sociologists and political scientists have examined national data sets to identify underlying dimensions of abortion attitudes. Political ideologies such as liberalism/conservatism (Kerlinger, 1984) were predictors of abortion attitudes, as were beliefs about economic welfare and individual liberty (Fleishman, 1988).

National Opinion Polls

Public opinion about abortion has been the focus of national polls, such as those by the Gallup organization since the 1960s. Attitudes have varied and continue to vary in terms of the reasons for the proposed abortion.

Variation by Sex

A national opinion poll indicated males were more supportive of abortion in cases of rape or incest (males 89%, females 81%), possible defect in the fetus (males 64%, females 56%) or to protect the mother's health (males 86%, females 83%). Both sexes were about equally likely

to support all abortions (males 80%, females 81%) (Gallup Report, February, 1989).

Trends in Abortion Attitudes Nationally

Consistently, the greatest support for abortion has been for medical reasons. Even restrictive state laws before Roe v. Wade (1973) generally allowed "therapeutic" abortions when they were performed by physicians and deemed "medically" necessary. In 1965 73% of the population approved of abortion when the woman's health was seriously endangered by the pregnancy (Rodman et al., 1987:137). Support for abortion to protect the mother's health has increased, so that 94% of those polled in 1989 indicated their approval if the woman's life were endangered, and 84% approved if the woman might suffer health damage (Gallup Report, February, 1989).

Approval for abortions in cases of rape increased to a greater extent over the same time period, from 59% in 1965 to 85% in 1989. Rodman et al. (1987) argue that abortion in cases of rape is a unique issue because rape is linked with "medical" reasons in the minds of the public. In instances of a possible serious defect in the fetus, support for legalized abortion increased from 57% in 1965 to 79% in 1985 (Rodman et al., 1987), but decreased to 60% by 1989. Attitudes are more favorable toward abortion in all instances in the 1980s than they

were before Roe v. Wade (1973) established a woman's right to chose (Gallup Report, February, 1989.)

The percentages indicating approval of legal abortion for nonmedical reasons have never been as great as those indicating support or approval of abortion for medical causes. Nonmedical reasons appearing most frequently in abortion attitude studies include if a woman is not married, if she is married but does not want any more children and if her family has very low income and cannot afford more children. In 1965 only 16% of the population believed not wanting any more children was a legitimate reason for legalized abortion. By 1982, 49% of the respondents expressed approval of legal abortion for married women. By 1985 that figure had decreased to 40%. Not being married was reason for approving of abortion for 18% in 1965, increasing to a high of 50% by 1974, declining to 41% in 1985. In 1965, 22% of those polled expressed approval of legal abortions for women whose families could not afford another child. By 1974, that figure had increased to 55%. A gradual decline followed and by 1985 only 44% expressed the same attitude (Rodman et al., 1987). In February 1989, only 19% of those polled approved of abortion if the family could not afford to have more children (Gallup Report, February, 1989).

Gradually general public support for legal abortion has increased. In 1975, 75% of those polled believed

abortions should be legal under some circumstances, while 22% believed all abortion should be illegal. In 1989, 81% indicated they believed abortions should be legal under certain circumstances. Only 17% of those polled indicated all abortions should be made illegal (Gallup Report, February, 1989).

Morality

Support for the availability of abortion and people's beliefs about the morality of abortion appear to be separate issues. A telephone poll taken for Time Magazine in April, 1989, found that 50% of those polled believed abortion was wrong and 47% favored stricter laws on abortion. Of those polled, 67% believed the decision should be left to the woman and her doctor.

Regional Abortion Attitudes

In March and April of 1989, a randomly selected sample of Tennessee residents were polled by the Social Science Research Institute at the University of Tennessee, Knoxville, about their attitudes toward abortion. Respondents were asked if abortion laws should remain the same, allow abortions only for some cases, or make abortion completely illegal. Only 17% of those polled expressed approval for completely outlawing abortions.

Some 45% indicated approval for restrictions in abortion availability and 38% believed the laws should not be changed. The sample was fairly evenly divided with 49% believing current laws on abortion were about right and 46% believing laws should be changed to make it more difficult to obtain an abortion. Only 5% believed abortion restrictions should be eased. A majority of the 1,011 adults polled (68%) believed the abortion decision should be left to a woman and her doctor (Knoxville News-Sentinel, 1989). The Tennessee poll found that abortion attitudes were related to religion, education and political identification.

CHAPTER IV

ATTITUDE THEORY

Individuals' beliefs about the social world have been investigated by sociologists, psychologists and political scientists because of their potential influence on behavior and social policy. More specific beliefs, known as attitudes, are often studied because they are presumed to have a more direct effect on behavior. Certain issues become the focus of controversy and are defined as social problems. Attitude research on such topics serves as a barometer of public opinion. Sociologists find such opinion polls useful in analyzing shifts in public sentiment.

Attitudes and State of Attitude Theory

Attitudes typically are defined as predispositions or states of awareness which shape how a social object is perceived, reacted to and remembered (Cohen, 1964).

Attitude theory has undergone some transformation in recent years. From an earlier emphasis on relationships between two or three attitudes, current theoretical focuses on schema or structure theories cast a wider net (Kluegel and Smith, 1986; Gamson and Modigliani, 1989).

Social scientists interested in interrelationships of attitudes developed theories of cognitive consistency

(Heider, 1946; Festinger, 1957; Newcomb et al., 1965). Others with an interest in cognitive structure have formulated theories of attitude structure (Cherlin and Walters, 1981; Fleishman, 1988). Some researchers believe there are connections underlying more general attitudes and beliefs or values. Their theoretical formulations focus on identifying underlying dimensions (Biaggio et al., 1985; Hastings and Hoge, 1986).

The most recent formulations in attitude theory are concerned with cognitive consistency but focus on how the patterns fit together. The nature of the relationships among and between attitudes is still elusive and schema theories evolved from efforts to identify the links.

This chapter explores the development of attitude theory in terms of cognitive consistency, attitude structure, underlying dimensions and attitude schema. The following sections discuss research pertinent to attitude theory formulation and findings germane to this study.

Cognitive Consistency

Relationships between attitudes are sometimes referred to as interdependence, other times as consistency. Consistency theories suggest people hold similar attitudes toward objects they believe belong together (Heider, 1946; Festinger, 1957). Twenty years ago, research efforts were likely to focus on cognitive

connectors between two or three attitudes. The goal was identification of the "kinds" of attitudes specific individuals endorsed (Newcomb et al., 1965).

Changes in public attitudes toward non-traditional roles for women has been a popular focus of research efforts, particularly since the Women's Movement of the 1960s and 1970s. In the search for consistency, sociologists found no relationship between attitudes toward women's issues and greater acceptance of non-traditional roles for women (Spitz and Huber, 1980). Others found steadily increasing support for women consistent with greater public awareness of women's issues (Cherlin and Walters, 1981). Current research indicates attitudes toward non-traditional gender roles are more consistent among adults who had childhood connections to non-traditional households (Smith, 1985; Kiecolt and Acock, 1988).

The effects of socialization on beliefs are another way the consistency question has been approached. Sociologists examined the consistency of attitudes about gender roles, political ideology and religion across three generations of family members in a test of socialization theory. Glass, Bengtson and Dunham (1986) failed to find consistency in attitudes toward gender roles, although other attitudes toward religion and politics were consistent.

Attitude Structure

Another way social scientists theorize about attitudes is in terms of structure. Structure refers to a predictable order where as attitude consistency focused on balancing operations. The structure of attitudes suggested by some sociologists may be political beliefs such as conservatism (Fleishman, 1988); social beliefs such as gender role traditionalism (Cherlin and Walters, 1981); or social structures such as class or marital status (Mason et al., 1976; Lynne and Rola, 1988).

Using national survey data, Fleishman focused on how social attitudes were structured around a specific political ideology. An "individual liberty" structure and an "economic welfare" structure of social, as well as political attitudes (Fleishman, 1988), did exist.

Structural roots of egalitarian gender attitudes, such as traditional division of labor, paid employment for married females and parent/child issues were investigated by others. Participation in the labor market did not provide the structure underlying gender role attitudes (Mason et al., 1976)

One researcher approached her topic of gender structure by grouping respondents in terms of their attitudes toward specific issues (i.e., careers for women, family traditionalism, the Women's Movement) to explain

variation in the other two attitudes (careers for women, family traditionalism or the Women's Movement) (Tomeh, 1978).

Attitude structure theory has been applied to research on social issues other than gender roles. For example, income was the social indicator expected to influence farmers' attitudes toward soil conservation, and an economic structure did underly willingness to undertake protection against soil erosion (Lynne and Rola, 1988). Individual farmers with higher incomes were less likely to have favorable attitudes toward conservation.

Underlying Dimensions of Attitudes

Researchers frequently refer to dimensions such as liberalism/conservatism, feminism/traditionalism or pro-labor/management as underlying reasons for attitudes. Attitudes toward issues of marijuana use and population control were measured at five times over a thirty-six year period (Hastings and Hoge, 1986). During the first twenty years underlying dimensions were liberal with respondents indicating approval of legalization of marijuana and a moral obligation to limit family size in the face of a perceived population crisis. Surveys during the later part of the study indicated an underlying dimension of conservatism; attitudes were opposite those found in the early part of the study (Hastings and Hoge, 1986).

Other researchers expected that women would differ on attitudes toward child-rearing, the population crisis, financial security, independence, and assertiveness based on their underlying beliefs in feminism. They found women who were opposed to feminism had more positive attitudes toward raising children with less concern about negative aspects of a population crisis (Biaggio et al., 1985).

Textile workers' underlying attitudes of pro-labor or pro-management on job related issues were uncovered by Leiter (1986). The better paid, long term workers held favorable attitudes toward the company while black, poorly paid workers expressed more positive attitudes toward a systems of "rewards on merit."

Attitudes Interrelationship

Other means of exploring the interrelationship of attitudes have been devised. By using statistical manipulation to identify correlations, then extracting major higher order factors, Eysenck (1978) identified two distinct attitude systems which he believed represented radicalism and conservatism. There was general support for a theory of attitude organization but no real breakthrough in new knowledge about how this organization could be identified.

Attitude Schema

Schema may be the most appropriate way to discuss how attitudes fit together. A schema is a device for organizing information about objects with which we come in contact, comparing that information with existing knowledge and placing it in logical categories. Schema have been applied to mental processes of gender identification and stereotyping for several years (Bem, 1983; Berkowitz, 1986). Interest which once focused on what type of social information is stored in schema and how is it organized now focuses on how existing schema affect subsequent information processing (Sherman et al., 1989; Gamson and Modigliani, 1989).

Analyzing attitudes in terms of schema may be relatively new but conceptualizations consistent with examining attitudes in terms of schema are not. Decades ago, Newcomb and his colleagues suggested that attitudes have "connectors" which act as organizers and "a person tends to have similar attitudes toward objects that he considers belong together" (1965:121).

Schema Theory

Schema theory as an approach to attitudes evolved out of early works in stereotyping and cognitive development. More recent sociological efforts to further develop the

theory focused on attitudes toward inequality (Kluegel and Smith, 1986) and attitudes toward nuclear power (Gamson and Modigliani, 1989).

How do individuals form opinions about any topic? Kluegel and Smith (1986) hold that we retrieve existing information from memory in the form of a schema or framework of beliefs. When people are in a position to form an opinion, specific aspects of the topic under consideration will "cue" or "call up" a relevant schema from memory. If an issue we encounter does not "cue" a particular schema, we adopt a "tentative" schema which is modified with subsequent information (Gamson and Modigliani, 1989). A schema will seldom cover all relevant facts of the topic. The crucial question for attitude research is what information is considered.

When we evaluate any object we note the most salient points. The same criteria apply when we search cognitive memory for an explanatory schema. Psychologists interested in how juries reach a verdict found subjects stored information in a schema rather than judging each bit of information as it was received. When called on to make a judgement, the salience of a verdict schema cues retrieval of the story schema from memory. By manipulating an item's inclusion in the story schema researchers succeeded in changing verdict choices. (Pennington and Hastie, 1988).

There appear to be three ways an object becomes salient: visibility, internalization and association. The most noticeable aspects of objects are the most salient (a common factor in stereotyping). Objects internalized as part of our self identity (such as feminism) may have increased salience because they are in a chronic state of availability. An object also may be salient because of an associated link with other salient concepts in our memory (Kluegel and Smith, 1986).

Unlike traditional attitude theories which consider consistency a necessary state, Kluegel and Smith (1986) argue that individuals may maintain inconsistent beliefs because they never consider those beliefs together. The "principle of cognitive efficiency" suggests our reliance on schema results in a variety of influences on attitudes toward new objects. The influences may be situational and fleeting (such as information from recent news items) or a stable underlying dimension (such as a belief in individual freedom or feminism) (Gamson, 1988).

Importance of Schema in Abortion Attitudes

Indications of the schematic nature of attitudes toward abortion have surfaced in several studies in recent years. For example, Luker (1984) found many of her subjects held similar views on abortion and on several related issues. These interrelated views could be

explained as products of an underlying schema. The term schema has become associated with the organization of various kinds of social cognitions and with the advancement of attitude theory.

This study addressed questions pertinent to the ongoing development of schema as an attitude theory.

Research Questions

A number of questions surfaced in the review of general attitudes toward abortion and pregnancy regulation, determinants of those attitudes and theory. These guided the collection and analysis of data. Questions that pertain to general attitudes toward abortion and pregnancy regulations were:

1. a. How do attitudes toward abortion held by residents of a Southeastern city in the "Bible belt" compare with national attitudes?

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- b. How do attitudes toward pregnancy regulation held by residents of that Southeastern city compare with those of other groups?

2. Are attitudes toward pregnancy regulation similar to attitudes toward abortion rights?

Questions pertaining to determinants of attitudes toward abortion and pregnancy regulation were:

3. Do correlates of abortion attitudes reported in

previous research also correlate with abortion attitudes in this study?

4. Do abortion attitudes and pregnancy regulation attitudes have the same determinants? (Are they similar models?)

5. Do conservative/liberal ideologies about religion, family/gender roles, individual rights underlie abortion and pregnancy regulation attitudes?

6. Does the medical model of pregnancy affect attitudes toward abortion and pregnancy regulation?

Further questions that have importance for this study relate to schema theory.

7. Is there an identifiable schema of abortion attitudes in this study?

8. Does the same schema underlie attitudes toward abortion and pregnancy regulation?

9. Do the findings from this research contribute toward clarification of schema theory?

10. Do the findings from this research contribute support for schema theory?

CHAPTER V

METHODS

The focus of this research was ascertaining public attitudes toward abortion and pregnancy regulation and ascertaining their determinants. Little is known about general public attitudes toward pregnancy regulation so a sample survey of a specific population was selected to provide some baseline data on those attitudes.

The general population sampled was residents of Knoxville, Tennessee. This city was chosen due to constraints of time and money. Residents of Knoxville may be more conservative about social issues than the general population nationwide, for they live within the area of the country frequently referred to as the "Bible belt" because of the high number of people involved in fundamentalist religions.

A telephone survey was chosen for data collection because mail surveys in areas of Tennessee are subject to low response rates which in part may be due to a low level of literacy. (Tennessee ranks 44th in the number of high school graduates with 56.4% of the population completing twelve years or more of education compared to a national average of 66.5% (County and City Data Book, 1988).) The

time required for face-to-face interviews would have necessitated limiting the size of the sample too much to be able to confidently generalize from the findings.

The Sampling Frame

The 1988 Knoxville, Tennessee, City Directory was chosen as the sampling frame. The directory includes a greater proportion of all individuals over eighteen than voter registration and other population lists. Telephone directory listings exclude individuals with unlisted numbers. Random digit dialing which addresses the problem of unlisted numbers results in lower response rates. The 1988 Knoxville, Tennessee, City Directory listed 175,045 adults who resided in the Knoxville city limits.

Beginning from a random point, every 437th name in the alphabetical list was drawn until names, addresses and phone numbers were recorded for a sample of 400. If no phone number was available for the 437th individual, the next individual with a telephone number was used as a replacement. This sampling form is an approved method of drawing a random sample (Babbie, 1983).

Development of the Instrument

A questionnaire was developed to ascertain attitudes toward abortion, pregnancy regulation, religion/secularism, family role liberalism/traditionalism, medical control, state/family or individual control and to collect socio-demographic data (Appendix A).

After the questionnaires had been printed, an error in numbering was discovered. There is no number seven (7) in the questionnaire used for this study.

Abortion Attitudes

National poll results on abortion attitudes are reported in The Gallup Report and Public Opinion, published by the Gallup Poll and the American Enterprise Institute for Public Policy Research, respectively. The accessibility of these polls and the reputations of the polling organizations led me to rely on them as sources for questions on abortion attitudes. I choose the most recent series of questions on abortion attitudes because they incorporated modifications based on findings from previous polls. (See The Gallup Report July, 1988; Public Opinion Sept./Oct. 1987; Public Opinion Nov./Dec., 1987; and Public Opinion Sept./Oct. 1986.)

The first question set selected asked respondents to indicate to what extent they agreed or disagreed with a woman's right to choose to have an abortion in a variety of circumstances. The circumstances were "if she wants it," "if she is married and doesn't want any more children," "if she is not married and does not want to marry the man," "if her family has very low income and cannot afford any more children," "if she is pregnant as the result of a rape," "if there is a strong chance of a serious defect in the baby," and "if her health is seriously endangered by a pregnancy." A second series of questions were selected which focused on the rights of biological fathers and parents of underage females. Respondents were to indicate to what extent they agreed or disagreed with the following statements using five Likert responses: "A husband should be notified if a wife is seeking an abortion," "A husband should have the right to prevent his wife from getting an abortion," "An unwed father should be able to stop his girlfriend from getting an abortion," and "A female under eighteen should be required to get her parents' permission before she can get an abortion." One additional question taken from a poll in Public Opinion (April/May, 1985) asked how personally concerned the respondent was about the abortion issue. Five response choices ranged from very concerned to not at all concerned.

Pregnancy Regulation

Glamour magazine polled readers about pregnancy regulation in March, 1988, using six questions (p. 142). Three questions from the Glamour study appeared applicable and were reworded to be consistent with the questionnaire. The revised questions asked respondents to what extent they agreed or disagreed with the following statements using five Likert responses: "Women whose babies are harmed by their failure to follow doctor's orders during pregnancy should be subject to criminal charges;" "If a female is pregnant, should a doctor be able to require that she have certain prenatal tests" and "Do doctor's have the right to require a pregnant woman to undergo medical treatment to benefit her fetus."

Two other questions about attitudes toward pregnancy regulation were drawn from a survey of medical professionals reported in the New England Journal of Medicine (Kolder, Gallagher and Parsons, 1987). The questions reworded for the general public were: "Do doctor's have the right to require a pregnant woman to undergo surgical delivery of her baby against her will" and "The government has a responsibility to stop women from engaging in behavior that endangers their unborn babies." The first item had five Likert responses which ranged from "always" to "never" and the second had five

Likert responses ranging from "strongly agree" to "strongly disagree."

Attitudes about pregnancy regulation also may be related to perceptions of actions that could be detrimental to the fetus. Legislation and judicial proceedings in recent years suggest increased concern about the effects of drinking and drugs on fetal development. Examples of this concern are local regulations requiring bars to post signs warning pregnant women against drinking and a new federal regulation that requires warning labels on alcoholic beverage containers. Concern about drug abuse has been apparent in passage of criminal laws and some widely publicized court cases. For example, an Illinois woman was charged with involuntary manslaughter in the drug related death of her newborn (Atlanta Journal and Constitution, May 11, 1989). Florida courts found a woman guilty of drug delivery to a newborn, (Knoxville News-Sentinel, July 14, 1989). And, a judge sentenced a woman to jail for the remainder of her pregnancy to prevent possible drug use (International Herald Tribune, July 30, 1988).

A question drawn from The Gallup Report (Nov., 1985) asked "For each of the following behaviors, please tell me how likely you believe it is that birth defects could happen if a pregnant woman does any of these things: exercises strenuously, fails to eat properly, smokes

cigarettes, drinks alcohol, uses drugs." Five Likert scale responses ranged from "very likely" to "very unlikely."

Secular/Religious Perspective

The relative importance of religion to a person has been correlated with attitudes toward abortion (Luker, 1984; Gelb and Palley, 1987). The perceived effect of religion on family life and frequency of attendance at religious functions may further indicate whether an individual has a more secular or religious orientation. To measure secularism three questions were drawn from Public Opinion (Nov./Dec., 1987, Feb./Mar., 1985) and The Gallup Report (Dec., 1986): "To what extent, if at all, has religion in your home strengthened family relationships;" "How important would you say religion is in your life," and "How often do you attend religious services." Five Likert scale responses to strength of religion ranged from "a great deal" to "not at all"; for importance of religion, five Likert responses ranged from "very" to "not at all" ; and the seven responses to church attendance ranged from "daily" to "never attend." A high score on these items indicated a secular orientation, that religion was of limited importance.

Family Roles

People's relative liberalism or traditionalism about family roles has been identified as a major influence on attitudes toward abortion (Luker, 1984). Two items were drawn from The Gallup Report (June, 1986) and Public Opinion (Sept./Oct., 1986) to address family traditionalism. One asked whether respondents identified themselves as more modern or traditional about family matters. Another asked respondents to choose one of five Likert agree/disagree responses to the statement "Men are best suited to the public world of work and women are best suited to care for home and family."

Medical Control

A medical model of reproduction is widely accepted by the general public (Schur, 1984; Luker, 1984; Eakins, 1986; Anderson, 1988). Because medical control of pregnancy and childbirth are widely accepted, attitudes toward medicine and medical control are expected to be related to attitudes toward pregnancy regulation.

Medical control questions were drawn from The Gallup Report (April, 1985; May, 1986; and Dec., 1987) and Public Opinion (Jan./Feb., 1988). Six questions addressed attitudes toward medicine and medical control in different situations:

a) "On the whole, how satisfied would you say you are with

the honesty and standards of behavior of doctors in this country?" (The five Likert responses ranged from "very satisfied" to "very dissatisfied.")

b) "Overall, how much do you trust your (family/personal) doctor's medical judgement?" (The five Likert responses ranged from "always trust" to "always distrust.")

c) "Do people have the right to refuse medical treatment for themselves even when the doctor orders it?"

d) "Do you follow your doctor's advice?"

e) "In your opinion, how often are doctor's right about medical diagnosis?"

f) "If a doctor considers certain medical tests necessary does the doctor have the right to require the patient to have those tests?"

The five item Likert responses for questions c, d, e and f ranged from "always" to "never."

Family/ State / Individual Rights

To explore attitudes about family, state (as protector of children), and individual rights orientations, questions were drawn from The Gallup Report (Sept., 1986; Sept., 1987; Dec., 1987) and Public Opinion (Sept./Oct., 1986; May/June, 1987; and Jan./Feb., 1988). Family rights measures were: "Who has primary responsibility for deciding what type of education a child should receive" as well as whether the topics of birth

control, sexual relationships, abortion and religion should be taught at home, in school, in church or not at all. Another question asked whether the responsibility for health care of children was parents', the state, doctors' or others. State responsibility for protecting children from parental abuse and neglect was the focus of two questions with Likert responses ranging from "strongly agree" to "strongly disagree:" "The state has a responsibility to protect children from possible harm from their parents" and "Parents who abuse their children should be subject to criminal charges." Also, respondents were asked to indicate on a scale from 1-5 their opinion of the State's role in "The removal of children from abusive homes" and "The removal of children from homes where they are neglected." Whether government has the right amount of power over people's lives was another question addressing state rights. Three responses ranged from "too much power" to "not enough power".

Questions about State or medical control discussed on the previous pages offered a choice of Likert responses. One end of the response scale indicated approval of external (medical or state) control while the other indicated approval of individual control. Individual rights were explored by asking respondents whether they agreed with the statement "People dying of incurable, painful disease should be allowed to end their

lives before the disease runs its course" by selecting one of five Likert responses (always to never).

Children's Rights

Two questions were included to address children's rights: "Do parents have the right to refuse medical treatment for their children for religious reasons" and "When a severely retarded infant is born with other defects that will kill that child unless surgery is performed, should the baby's parents be able to refuse that surgery." Both questions had five item Likert response categories ranging from "always" to "never."

Social and Demographic Characteristics

Attitudes toward abortion may vary by sex, education and income (Luker, 1984), so information about these demographic characteristics was collected. Political identification and class identification also may affect abortion attitudes (Cherlin and Walters, 1981; Kerlinger, 1984). A question about marital status was included although no relationship between marital status and general public abortion attitudes has been established. All demographic, political identification and class identification questions used for this study were drawn from Public Opinion and The Gallup Report. Occupational information was collected as an additional indicator of

social class. Because Knoxville has a predominately white population (93.2% in 1980), race was not included as a variable (The Tennessee Statistical Abstract, 1989).

Telephone Survey Construction

Telephone survey instruments require special construction. Respondents' attention must be gained and maintained for a long enough time to complete all questions (Dillman, 1978). Interest getting questions were used at the first of the questionnaire to capture and periodically throughout the instrument to maintain respondent interest. Transitional statements were used to introduce new topics and ease the transition from one topic area to another. Response categories were repeated frequently so that respondents would not be required to remember responses at the same time they considered new information.

Wherever possible the ordering of questions followed Dillman's (1978) suggestions about questionnaire and interview construction. First, respondents' opinions about various family rights and responsibilities were asked. The lead question was non-threatening ("who has primary responsibility for deciding what type of education a child should receive"), clearly related to the stated purpose of the study (to find out what people believe

about the roles of government, doctors and families in decisions and when individuals have the right to make their own decisions) and close-ended with three response categories. Series of questions about potentially more controversial topics were not asked consecutively. Demographic and personal information was sought at the end of the interview to be less threatening to respondents (Dillman, 1978).

Reliability and Validity

One effective procedure often adopted in social science research is to use measures that have proven reliable in other studies. Questions for this study were selected from prior research and many questions (such as those dealing with the abortion issue) have been used by numerous national polls. A few questions were reworded to fit the overall questionnaire format. When questions had to be reworded commonly understood terms were used to protect the reliability of the measure. Operational definitions of the concepts indicate face validity.

Pre-test

A pre-test of the interview instrument was carried out by a methods class under the direction of Dr. Donald

W. Hastings. One hundred questionnaires were distributed to students on the University of Tennessee, Knoxville campus. Respondents were informed that the questionnaire was a pre-test for a future study.

The lack of interviewer instruction resulted in multiple answers to some questions. These questions were reviewed and clarified, if necessary. (For example, the following questions "For each of the following topics, indicate whether in your opinion the topic should be taught: in school, at home, in church or should not be taught" was clarified by rewording the questions to specify that the topic should be taught "primarily" by one institution.)

The question asking the respondents to identify themselves as traditional or modern about family roles apparently was ambiguous and was dropped. It was replaced with three questions from Public Opinion (Dec./Jan., 1986; July/Aug., 1988) and a series of questions from the General Mills Family Survey (1981) which identify traditional beliefs about the family and gender roles. The following eight statements with five Likert scale responses ranging from strongly agree to strongly disagree were the items drawn from both sources and added to the measure of liberal/traditional family roles:

a) "Children need stronger parental guidance, supervision and discipline than can be given when both parents work."

- b) "When both parents work children are more likely to get into trouble."
- c) "Even when they don't work, parents today don't give their children the time and attention they need."
- d) "It would be a good thing for families if schools provided more care before and after school hours."
- e) "It would be a good thing for families if there were more day care centers and other child care services outside the home."
- f) "Whenever possible, women should stay home if they have young pre-school children."
- g) "While there are some exceptions, the statement that woman's place is in the home still makes sense."
- h) "It is more important for a wife to help her husband's career than to have one herself."

Items measuring abortion attitudes and attitudes toward pregnancy regulation were scored. High scores favored a pro-choice position and opposed pregnancy regulation. The pre-test results were examined to establish how reliable the proposed scale items were as measures of attitudes toward abortion and attitudes toward pregnancy regulation. The Cronbach's alpha reliability coefficients for the two dependent variables were .81 for attitudes toward pregnancy regulation and .97 for attitudes toward abortion. Two questions intended to measure pregnancy regulation were inadvertently omitted

from the scaleability check by the students: "The government has a responsibility to stop women from engaging in behavior that endangers their unborn babies" and "Women whose babies are harmed by their failure to follow doctor's orders during pregnancy should be subject to criminal charges."

Informed Consent

Social researchers are responsible for protecting the respondents in research studies from possible harm. To guard against potential harm such as invasion of privacy, anxiety, discomfort or demeaning procedures a method of informed consent is employed. Informed consent requires an explanation of the research, identification of the researcher, and description of any possible risks to the subject (Bailey, 1982). Approval was applied for and obtained from the campus committee for human subjects research. An informed consent statement was included in a letter mailed to respondents before they were contacted by telephone (Appendix B). Agreeing to answer the questions constituted informed consent. If participants had not received the letter, the parts pertinent to informed consent were read to them before starting the interview.

Contacting the Sample

To improve the response rate, letters which contained a brief explanation of the project, asked for the respondent's cooperation, assured the respondent of confidentiality and identified the interviewer were mailed to those whose names were drawn. I was conducting all telephone interviews without assistance, so the letters were mailed out in stages to prevent a large time lag between receipt of the letter and the telephone call. The first fifty letters were mailed three days before any phone calls were made. By the time attempts had been made to contact all fifty individuals, some had forgotten receiving the letter or the letter's contents. Subsequently letters were mailed to 25 or less at one time.

A total of 30 letters were returned. All but one of the returns were because individuals had moved leaving no forwarding address or because the forwarding order had expired. Only one return noted the addressee was not known at that address.

Calls were placed between 6:30 p.m. and 10:00 p.m. week nights. Every effort was made to contact respondents at a convenient time and I returned calls early in the morning, late at night, on weekends, during the day or at

any other time specified by respondents or others answering the phone when respondents were not at home. At least four attempts were made to contact each person including one call back at a different time (e.g., during the day if other calls had been placed at night and were unanswered or on weekends if there was no answer on weekdays). Respondents apparently preferred not to be interviewed on weekends (there were more requests to call back at another time), so I avoided calling on weekends except for difficult to reach people or when requested to do so.

Directory information was checked for new numbers for disconnects, but 41 individuals with disconnected numbers still could not be reached. There were four (4) individuals in the sample who were deceased and six (6) who were unable to participate due to illness or infirmity. One deaf respondent asked that her daughter interpret for her because she did not hear well over the phone. The interview was conducted with the daughter responding for her mother.

I was unable to contact 63 of those who were mailed letters. Most failures to contact were repeated calls with no answer but a few were spouses whose wife or husband refused to let them talk to me or parents who would not allow me to speak to their son or daughter. The refusal rate was 15%.

The interviews were conducted from December 5 through April 26, skipping ten days during the Christmas holidays from December 18 through December 28. By April I had nearly exhausted the list of 400 names. People apparently were more difficult to reach as the weather became warmer and the days longer.

In April, the publicity surrounding the abortion issue increased markedly. The Supreme Court of the United States was asked by the federal government to reconsider Roe v. Wade while reviewing the Missouri abortion law. The result of a telephone poll of Tennessee residents (University of Tennessee Research Institute) about the abortion issue appeared in the local paper. There was some confusion among those I called (many believed the research discussed in the paper was the study referred to in the letter they received), and an increase in refusals. Four or more persons indicated the excessive publicity surrounding the issue was a factor in their refusal. Those who did participate were more likely to chose to omit answers to some questions. One person refused to continue the interview when the topic of abortion was introduced. (The incomplete interview was considered a refusal.)

A total of 382 letters had been mailed when the publicity surrounding the abortion issue reached a level

where it posed a threat to validity, with the consent of the committee the interviewing was discontinued.

Statistical Analyses

Prior research in sociology on attitude schema (Kluegel and Smith, 1986) used regression analysis as the statistical technique. The measures developed for this study were consistent with those required for regression computation and multiple regression analysis was chosen as an appropriate test of schema theory.

SPSSX was used for all data analysis. Modern statistical packages for computer analysis guard against and warn the researcher of multicollinearities during regression procedures. Tolerance levels of all variables are computed at each step of the equation. Variables are not entered if the equation is less than .01 (the default). Default tolerance criterion were used for the regression procedures in this study (Norusis, 1985).

The task of the data analysis was threefold. First, percentages were computed for abortion and pregnancy regulation questions in order to compare this sample with prior research findings. The second and third goals were to develop a model to predict abortion attitudes and to test the usefulness of the model for predicting attitudes toward pregnancy regulation.

Pearson's correlation coefficients were computed of the dependent variables and variables expected from prior research to be significantly related to pro-choice attitudes. A correlation matrix was constructed and significant relationships between all dependent and independent variables were scrutinized for collinearity.

To ascertain if there was an underlying schema for pro-choice, multiple regression analysis was performed. The model with the greatest explanatory power and the best fit for pro-choice attitudes was identified.

Multiple regression analysis was performed with anti-regulation as the dependent variable, pro-choice and the variables in the pro-choice model were the independent variables. When the independent variables significant in explaining the variation in pro-choice attitudes proved not significant when regressed on anti-regulation, a search was undertaken to identify an anti-regulation model.

The original correlation matrix was scrutinized for variables significantly related to anti-regulation. Multiple regression analysis was performed to ascertain the underlying schema of anti-regulation and the regression model with the greatest explanatory power and best fit for anti-regulation attitudes was identified.

CHAPTER VI

CHARACTERISTICS OF SAMPLE

A total of 201 telephone interviews were completed. The respondents ranged in age from 18-93. The median age of the sample was 46 with 18.9% of the respondents age 65 or older. Census data indicated 11.2% of the Knoxville population was 65 or older in 1980, so the sample had more older people than might be expected if adults of all ages were equally likely to respond. Older Americans are more likely to own their home, have the same phone number for many years and less likely to be working long or irregular hours. For all of these reasons a larger number of respondents may have come from this age group. Somewhat less than 10% of the subjects were 25 or younger. Compared to older individuals in the sample, the younger group is more likely to move frequently, have occupations that require long hours, work hours other than 9:00 to 5:00 and be involved in social activities and away from telephones during non-work time. These characteristics may account for the disproportionately low number of respondents from this age group.

Males constituted 43.3% of the sample; 56.7% were females. The majority (68.2%) of the sample were

married. The remaining respondents were single (widowed 7.5%, divorced 8.5%, never married 15.9%).

According to the 1988 County and City Data Book, 61.4% of the Knoxville population in 1980 had completed 12 years or more of schooling. Of my sample, 66.1% had either completed high school or a trade or business school. Those with less than 12 years education constituted 13% of the sample. High school was the extent of education for 25% of my sample while 27.9% had attended a two year college or business school. Of those who had completed college (34%) there were 13% with advanced degrees.

A total of 23% of the sample had yearly family incomes of less than \$20,000. About half of those (10% of the sample) had incomes less than \$10,000. (The Tennessee Statistical Abstract for 1989 indicated 10.8% of all families in the Knoxville metropolitan area had incomes below the poverty level.) Less than a fourth (21%) reported family incomes between \$20,001 and \$30,000, 23% between \$30,001 and \$40,000 and 32% over \$40,000. The rate per 1000 of the population engaged in professional or technical occupations is 187.1. Production workers, craftsmen, operators comprise 189.0 of the rate per 1000. In 1980, 17.4% of the population had completed 16 years of schooling or more.

The sample characteristics and those of the Knoxville metropolitan area population listed in 1988 County and City Data Book and Tennessee Statistical Abstract (1989) do not differ substantially.

Comparison of Attitudes

Knoxvillian's attitudes toward abortion were somewhat more conservative than attitudes on a national level (See Table I). National attitudes had been the focus of several polls in 1988 and 1989 as the U. S. Supreme Court decision to hear an abortion case focused attention on beliefs about the availability of abortion. Locally, 86% believed women whose health was endangered by a pregnancy should be able to obtain an abortion. Nationally, 94% endorsed this position in 1989, up from 89% in 1988. The availability of abortion in cases of rape was favored by 76% of the Knoxvillians compared to 89% nationally in 1989 and 81% in 1988. Only 70% of the local respondents believed a serious defect in the baby was adequate reason for an abortion while the national poll indicated 81% in 1989 and 78% in 1988 endorsed abortion in that instance.

Respondents in this study indicated attitudes nearer those nationally in other circumstances. The availability of abortion in cases where the family had very low income and could not afford more children was supported by 43% of

TABLE I
COMPARISON OF ATTITUDES TOWARD ABORTION AVAILABILITY

Abortion should be available if:	<u>Percent agree</u>		
	National* 1988	1989	Knoxville, Tn. 1988/89
Woman's health is endangered	89%	94%	86%
Pregnancy is the result of rape	81%	89%	76%
Chance of serious defect in baby	78%	81%	70%
Low income, family cannot afford child	42%	46%	43%
Woman is not married	40%	44%	44%
Woman married, does not want child	40%	40%	38%

* National results from Public Opinion (May/June, 1989)

the Knoxvilleians, 46% of the national poll (1989) and 42% of those polled nationally in 1988. Attitudes favoring abortion if the woman was not married were consistent with those held nationally in 1989 (44%). This was an increase from 40% in 1988. National polls in 1988 and 1989 indicated 40% of respondents believed abortion should be available to married women who did not want any more children, 38% of the local respondents agreed.

The Knoxville sample indicated a greater willingness to regulate pregnancy than was indicated in other studies (See Table II). A majority believed a doctor should be able to require a pregnant female to have prenatal tests (69%) compared to 54% of the respondents in other polls. Locally 73% believed doctors should be able to require pregnant women to undergo medical treatment to benefit the fetus while the Glamour poll found 49% believed doctors should have that authority. Government responsibility to stop women from engaging in behavior that might endanger their unborn babies was endorsed by 62% of the Knoxville respondents compared to 46% in the study of physicians. Physicians were more likely to support a doctor's right to require a pregnant woman to undergo surgical delivery of her baby against her will (47%) when compared with local respondents (43%). The Glamour poll indicated slightly more approval for women whose babies are harmed by their failure to follow doctor's orders during pregnancy being

TABLE II

COMPARISON OF PREGNANCY REGULATION ATTITUDES OF PHYSICIANS,
GLAMOUR MAGAZINE READERS AND KNOXVILLE, TN. SAMPLE

Questions: a	<u>Percent Agree</u>		
	Physicians 1987*	Glamour Readers 1988**	Knoxville, Tn. 1988/89
If a female is pregnant, should a doctor be able to require that she have certain prenatal tests.		54%	69%
Do doctor's have the right to require pregnant women to undergo medical treatment to benefit her fetus.		49%	73%
Do doctor's have the right to require a pregnant woman to undergo surgical delivery of her baby.	47%		43%
The government has a responsibility to stop women from engaging in behavior that endangers their unborn babies.	46%		62%
Women whose babies are harmed by their failure to follow doctor's orders during pregnancy should be subject to criminal charges.		46%	43%

* N = 57

** N = 857

a
questions wording varies slightly between studies.

subject to criminal charges (46% compared to 43% of the Knoxville respondents).

CHAPTER VII

DEVELOPMENT OF MEASURES

Abortion and Pregnancy Regulation

Sixteen items which on the face appeared to be measures of the two dependent variables, attitudes toward abortion and attitudes toward pregnancy regulation were subjected to exploratory factor analysis (question 3; sections e, f, and g of question 10; sections c and d of question 14; all sections of questions 17, 18, and 19.)

Exploratory factor analysis is designed to find independent underlying dimensions of items and to indicate the correlation between each item and each dimension. Orthogonal rotation was selected because factors are rotated so that they can be assumed to be uncorrelated. Although Bailey (1982) suggests a factor loading of at least .4 is sufficient to be part of the factor scale, a more conservative minimum loading of .5 was used for inclusions.

Two distinct factors were generated. The factors were labelled pro-choice and anti-regulation to be consistent with the direction of the scale items. High scores favored a pro-choice position and opposed pregnancy regulation. Nine items formed the pro-choice factor and

five items the anti-regulation factor. The Chronbach's alpha reliability coefficient for scales formed from these items were .91 for pro-choice and .70 for anti-regulation (See Table III).

Gender Liberalism/ Secular and Medical Control

A second factor analysis was performed on eighteen items dealing with family or gender role attitudes, religious or secular attitudes, and attitudes toward medical control using varimax extraction with orthogonal rotation. These items were responses to questions 8, 9, sections a, b, c, and d of question 10 (section a was recoded so that answer categories were reversed); questions 20 (section d and e were recoded, answer categories were reversed), 21, 22, 23 and 24. (Question 24 was recoded with responses 1 and 2 = 1, responses 3 and 4 = 2, response 5 = 3, 6 = 4 and 7 = 5 because few 1 or 4 responses were given.)

Three factors were generated (See Table IV). Six gender items formed a factor; these items were used as a gender liberalism scale. The alpha reliability coefficient for the scale was .79. Three religious items loaded on one factor. When scaled, one item measuring attendance at religious services did not add to the scale reliability, so the item was deleted. The remaining items

TABLE III
FACTOR LOADINGS: PRO-CHOICE AND ANTI-REGULATION ITEMS

ITEM	PRO- CHOICE	ANTI- REGULATION
Abortion for unmarried	.85969*	.13226
Abortion by choice	.82212*	.15900
Abortion if poor	.82118*	.14463
Abortion if married	.78831*	.25275
Abortion in cases of rape	.77851*	-.08088
Abortion if fetus defective	.76706*	-.11002
Right of husband to prevent	.65472*	.19846
Abortion to protect health	.62787*	-.07133
Right of unwed father to prevent	.60999*	.07841
Require treatment to benefit fetus	.06520	.75939*
Require testing to benefit fetus	-.07929	.69248*
State should protect unborn	.15082	.60651*
C-section over mother's objections	-----	.60349*
Prosecute women for fetal abuse	.13436	.58505*

* Loading > .5

TABLE IV
FACTOR LOADINGS: GENDER LIBERALISM, SECULAR AND MEDICAL
CONTROL ITEMS

ITEM	GENDER LIBERALISM	SECULAR	MEDICAL CONTROL
Women's place in home	.70689*	.31847	.14080
Child lacks support, dual work	.69827*	-----	.16504
Child misbehaves, dual work	.68582*	-.11492	.17183
Preschoolers need mother	.63820*	.06457	-.09942
Separate male/female spheres	.61351*	.31311	.17064
Wife is career helpmate	.54028*	.35563	.10492
Strength of religious beliefs	.11480	.86938*	-----
Importance of religion	.15642	.83838*	-----
Religious participation	.09745	.83052*	-.07025
Trust doctors	-----	-----	.68366*
Honesty of doctors	-.17290	-.05551	.63251*
Take doctor's advice	.10401	.20058	.59280*
Infallibility of doctor's diagnosis	-.07445	-----	.50845*

* Loading > .5

were used to form a secular scale. The alpha reliability coefficient for the two item secular scale was .86.

Six items related to medical control loaded on a factor. The scale of those items had an alpha reliability coefficient of .46 which was unacceptable. Dropping the three items with the lowest loadings from the scale raised the alpha coefficient to .51. The scale was rejected due to its low reliability. Examination of the frequencies for the items showed skewed distributions with overwhelming approval of medicine and doctors on five of the six items. Responses on only one item (Question 10, section d) "If a doctor considers certain medical tests necessary does the doctor have the right to require the patient to have those tests?" were reasonably distributed.

Family Control Measures

Attitudes about underage females obtaining birth control pills or devices without parental consent and about requiring parental permission for an abortion for an underage female were expected to be related to attitudes about the family. Responses to the question about underage females obtaining birth control were skewed toward a belief that parents should always be informed. Responses were recoded to form a dummy variable of "always" (0) and "sometimes" (1).

Advocates of family rights presumably would favor parental control of school curricula and oppose the schools providing education on sexual matters. Responses to who should control school curricula were recoded to a dummy variable with 1 = family control of education and 0 = all other. Responses to who should be responsible for education about birth control were recoded to a dummy variables with 1 = family control and 0 = all others. A question about who should teach children about sexual relationships was not used due to the lack of variation in response. Almost 80% of the sample thought explanations of sexual relationships should be undertaken at home.

Measures of Children's Rights

One question asked if parents should be able to refuse life saving surgery for a severely retarded infant. A high score reflected concern for preserving life of the child regardless of parents' wishes.

Whether parents have the right to refuse medical treatment for their children for religious reasons was another question. Over 50% of the sample indicated parents should never have that right. Responses were recoded to a dummy variable with 0 = never and 1 = sometimes.

A third question concerning the state's right to remove children from abusive homes was so strongly

supported by all respondents that it was not included in the analysis.

Individual Rights Measure

Belief in individual rights was addressed by asking whether people should be allowed to end their own lives when suffering a terminal disease. A low score indicated people should be allowed to make their own decision.

Other Measures

In response to a question about whether government had the right level of power, only 3% believed government did not have enough power. The item was recoded to a dummy variable (the "not enough power" cases were treated as missing cases) government having about the right amount of power and government having too much power.

Sex was coded as a dummy variable (0 = female, 1 = male).

Pearson's Correlations

Pearson's correlation coefficients were computed with the dependent variables, demographic variables and other independent variables. The significance level used for all correlations was $p < .05$. Variables that were significantly correlated with either dependent variable (pro-choice or anti-regulation) were selected for

inclusion in a correlation matrix (See Table V). The relationships of variables in the matrix were scrutinized for collinearity.

Associations between socio-demographic and attitudinal variables suggested by other research findings as significant in explaining abortion attitudes were examined.

Socio-demographic Variables

Marital status was not significantly correlated with measures of anti-regulation, pro-choice, gender liberalism, or doctor's right to require patients to have tests and had a low correlation with secular (-.12). Marital status was omitted from subsequent analysis because of the absence of significant correlation and absence of theoretical reasons for retaining it.

Income was not significantly related to either anti-regulation or pro-choice attitudes. There was no significant relationship between age and anti-regulation or pro-choice, although age was negatively related to gender liberalism (-.49) and secular (-.23). Older subjects had more traditional beliefs about family/gender roles and a more religious orientation. The absence of a significant correlation with either dependent variable and lack of a theoretical tie to attitudes toward abortion or

TABLE V

CORRELATION MATRIX REPRESENTING THE RELATIONSHIPS
AMONG PRINCIPAL VARIABLES IN THE ANALYSIS

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. ANTIREG	1.00													
2. PCHOICE	.21***	1.00												
3. DOCTORS	.42***	N.S.	1.00											
4. GEN.LIB.	.21**	.38***	.18**	1.00										
5. SECULAR	.12*	.41***	N.S.	.32***	1.00									
6. BIRTH C.	.19**	.33***	.15*	.47***	.19**	1.00								
7. DEFECT.	-.21**	N.S.	N.S.	N.S.	N.S.	N.S.	1.00							
8. P. REFUSE	.17**	N.S.	N.S.	N.S.	N.S.	.12*	N.S.	1.00						
9. POL.ID	N.S.	.33***	N.S.	.34***	.24***	.23***	N.S.	N.S.	1.00					
10. EDUC.	.17**	.23***	N.S.	.31***	N.S.	.23***	.22***	.17*	N.S.	1.00				
11. SEX	.13*	N.S.	N.S.	-.16*	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.	1.00			
12. INDIV.	.18**	-.46***	-.18**	-.28***	-.25***	-.18**	.15*	N.S.	-.19**	-.18**	N.S.	1.00		
13. P. PERMIS	.26***	.47***	.12*	.30***	.31***	.44***	N.S.	N.S.	.25***	N.S.	N.S.	-.26**	1.00	
14. SCHOOL	N.S.	-.34***	N.S.	-.17**	-.21**	N.S.	N.S.	N.S.	-.16*	N.S.	N.S.	.20**	-.18**	1.00

* p < .05 ** p < .01 *** p < .001

pregnancy regulation resulted in the omission of income and age in subsequent analyses.

Education was related to pro-choice (.23) and anti-regulation (.17) in the expected direction with a positive correlation between higher levels of education and liberal attitudes about the family, pregnancy regulation and abortion. Sex was positively correlated with anti-regulation (.13) but there was no significant relationship with pro-choice attitudes.

Attitudinal Variables

Correlations were run to explore the relationships between the dependent variables (pro-choice and anti-regulation) and other attitude measures. Secular was strongly correlated with pro-choice (.41) with a much weaker relationship to anti-regulation (.12). Attitudes about doctor's right to require patients to have tests (.42) and gender liberalism (.21) were positively correlated with anti-regulation. The item measuring beliefs about doctor's right to require patients to have tests was not significant in relation to pro-choice but gender liberalism and pro-choice were positively correlated (.38) as expected. Research on attitudes indicate a relationship between a liberal political identification and attitudes toward less traditional family roles. Gender liberalism attitudes were positively

correlated with political liberalism (.34) consistent with other study findings.

One measure of parental control of underage females, parent's right to control daughter's access to birth control was correlated with anti-regulation (.19) and pro-choice (.33) in the expected direction. Both parent's right to control access to birth control and attitudes about parental permission to obtain an abortion were correlated in the expected direction with gender liberalism. Birth control attitudes were negatively correlated (-.44) and parental permission had a positive relationship (.30). The access to birth control measure was also correlated with secular (.19). People with liberal attitudes toward family gender roles indicated less approval of controlling sexual behavior of female offspring.

Of the five activities respondents might perceive as affecting fetal development, two proved to be significantly related to anti-regulation, beliefs about exercise (.17) and beliefs about eating (.16). The latent effects of poor nutrition on the unborn is unresolved but exercise has been shown to be beneficial to both the pregnant female and the fetus. Beliefs about exercise was correlated with pro-choice (.27), anti-regulation (.17), gender liberalism (.29) and education (.30). People who are less informed about fetal

development indicate a greater willingness to censor a woman's behavior.

Attitudes about parent's right to refuse surgery for severely retarded newborns negatively correlated with anti-regulation (-.21). The correlations between state responsibility for preventing child abuse and anti-regulation or pro-choice were not significant possibly due to the lack of variation in the responses to the question addressing state responsibility for children. Attitudes about refusing medical care for a child for religious reasons had a low correlation with anti-regulation (.17) but had no significant relationship with pro-choice, secular or doctor's right to require patients to have tests. Beliefs about the amount of power the government had over individuals was correlated with political identification (.14) and education (.17) but not with either dependent variable, pro-choice or anti-regulation.

Ranges, means and standard deviations of all variables referred to in the findings are presented in Table VI.

Multiple Regression Analysis

Multiple regression analysis was performed to ascertain the underlying attitudes in pro-choice. Criteria for inclusion in the regression was significance

TABLE VI
RANGE, MEANS AND STANDARD DEVIATIONS FOR
INDEPENDENT AND DEPENDENT VARIABLES

VARIABLES	RANGE	MEAN	S.D.
Anti-regulation	5-25	12.57	4.25
Pro-choice	9-45	29.54	10.56
Secular	2-10	3.34	1.97
Gender liberalism	6-30	16.42	5.93
Doctors right	1-5	3.00	1.42
Defective newborn	1-5	2.83	1.43
Parents refuse	0-1	.42	.49
Birth control	0-1	.47	.50
Political ID	1-5	2.56	1.05
Education	1-7	4.35	1.74
Gov. power	1-2	1.55	.50
Age	18-93	47.87	17.26
State protect	1-5	1.47	.78
Parental permission	1-5	1.80	1.32
Individual right	1-5	2.79	1.51
School	1-2	.69	.47
exercise	1-5	3.34	1.28
nutrition	1-5	2.08	1.11
smoking	1-5	1.74	1.04
drinking	1-5	1.63	.94
drug use	1-5	1.13	.53

N=201 all except ANTIREG (N=198), BIRTH CONTROL (N=200)

in previous research on abortion attitudes and significance in the correlation matrix. The variables of greatest value in explaining pro-choice were secular, followed by political identification, parent's right to control access of birth control by daughters and education. Gender liberalism did not meet minimum requirements for inclusion and was dropped during the stepwise regression on pro-choice.

Measures of individual and family rights (individual's right to end own life, parent's permission as requirement for abortion and family's right to control education) were regressed on pro-choice. When the variables measuring concern for the child and beliefs about individual rights were introduced into a stepwise regression, parent's right to control access of birth control dropped out. The final regression identified a model with six variables (parental permission should be required before abortion is performed on underage female, individuals should have the right to end their own lives, secular, parental control of education, political identification and education) that explain 45% of the variation in attitudes about abortion. Standardized regression coefficients for the pro-choice model are presented in Table VII.

To explore whether the same or similar schema underlay the pro-choice and anti-regulation positions, the

TABLE VII
REGRESSION MODELS FOR PRO-CHOICE AND ANTI-REGULATION

VARIABLE	PCHOICE		ANTIREG	
	b	BETA	b	BETA
SECULAR	1.035	.193*		
POL. ID	1.498	.149*		
EDUCATION	.737	.121		
INDIVIDUAL	-1.740	-.249*		
SCHOOL	-3.402	-.150*		
PAR. PERMIS.	2.167	.272*	.604	.189*
DOCTORS RIGHT			1.134	.379*
DEFECT. NEWBORN			-.555	-.187*
P. REFUSE			1.049	.122
SEX			1.072	.125
CONSTANT	22.271		8.699	
F	26.375*		15.172*	
2				
R	.451		.283	

* p < .01

independent variables significant in explaining the variation in pro-choice attitudes were regressed on anti-regulation. Pro-choice was included as an independent variable in the regression on anti-regulation. The variables of greatest value in explaining pro-choice were not related to anti-regulation at any significant level.

To develop a model of anti-regulation, the correlation matrix was inspected. Variables identified as significantly related to anti-regulation attitudes were included in a stepwise regression on anti-regulation.

Doctor's right to require patients to have tests was the first variable included in the stepwise regression selection, accounting for the greatest amount of variation in antiregulation followed by parent's right to refuse lifesaving surgery for defective newborn, pro-choice abortion attitudes, parent's right to refuse medical treatment for their children and sex.

Measures of individual and family rights (individual's right to end own life, parental permission as a requirement for an abortion for an underage female, parent's right to control school curricula) were regressed on anti-regulation. Only the measure of parental permission for an abortion was significant in the regression analysis however, pro-choice dropped out of the regression model at this point. The final regression identified five variables (doctor's right to require

patients to have tests, parental permission as a requirement for abortions for underage females, whether parent's have the right to refuse medical intervention for defective newborn, sex and whether parent's have the right to refuse medical treatment for their children for religious reasons) that explain 28% of the variation in attitudes toward pregnancy regulation. Standardized regression coefficients for the anti-regulation model are also presented in Table VII.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

This project had three primary goals: to establish the distribution of attitudes toward pregnancy regulation for a general population sample, to compare the regression models explaining attitudes toward pregnancy regulation and abortion and to evaluate schema theory as a means to explain attitudes toward these two issues--one of which is the focus of widespread debate and one which has the potential to become the focus of debate.

A general population survey of a sample of Knoxville, Tennessee, residents revealed that they had more conservative attitudes toward pregnancy regulation than Glamour Magazine readers which may be a reflection of their representing a broader spectrum of the population (e.g. more diverse ages and education levels) and the effects of residing in a conservative region of the country. Knoxville's attitudes toward abortion could be compared with those of national population samples; Knoxville's attitudes were supportive of abortion choice but less so than nationwide samples.

If the same schema produces attitudes toward abortion and toward pregnancy regulation they should be closely connected. Only a moderate correlation was found to link the two attitudes and explanatory variables were quite different.

Research on abortion attitudes indicates strong relationships between gender liberal attitudes and pro-choice views of the abortion issue (Luker, 1984; Fleishman, 1988). This study found a correlation between the two but knowledge of attitudes about gender liberalism did little to explain the variation in attitudes toward abortion. Gender liberalism was not part of the final abortion model.

"I think when you get this all together and look at it, you'll find out religious beliefs explains how we feel about all these other issues" suggested one respondent. A link between individual religious/secular attitudes and attitudes toward abortion was supported in this study consistent with the suggestion and prior research findings.

The vocal debate over abortion has emphasized two positions: pro-choice and pro-life. Apparently many members of the public have accepted the presentation of abortion as a matter of individual rights to make a choice. Proponents of individual rights were expected to oppose state control of a person's behavior, whether the

behavior was seeking an abortion or objecting to undesired legal or medical intervention in a pregnant woman's life. An individual rights orientation in attitudes appears to underlie attitudes about abortion. "Abortion decisions should be the individual's, even for young girls", "I think people have a right to make up their own mind" and "No one should be able to tell a woman what she can do with her body" were some of the comments of respondents.

The findings lead to a conclusion that concern about individual rights is not part of a schema underlying attitudes toward pregnancy regulation. Neither were religious/secular attitudes important in explaining pregnancy regulation.

Proponents of children's rights were expected to support intervention on behalf of the child or potential child. Beliefs about parents' rights to refuse medical care for children for religious reasons were a factor in explaining pregnancy regulation. Only when the state intervened in individual affairs to protect a child from abuse was there any support for state's rights. Approval for state's rights therefore seems an unlikely schema to account for attitudes toward pregnancy regulation. One respondent voiced a concern about government control in reproductive decisions. "I don't like government intrusion. People get too emotional about abortion and these other issues. They don't look ahead to the

consequences of 'big brother' making our decisions for us."

The only variable in the final models for both abortion and pregnancy regulation was a belief that parental permission should be required before an underage female could obtain an abortion. It is difficult to draw a conclusion about where this belief originated, in concerns for family rights or concerns about control of reproductive issues.

Underlying both attitude models are differing beliefs about control. An individual control schema may underlie pro-choice attitudes while medical control may be the schema drawn on to form anti-regulation attitudes.

Included in the anti-regulation attitude model were approval of a doctor's right to require a patient to undergo treatment, disapproval of parents' right to refuse life saving surgery for a defective newborn and disapproval of parents' right to refuse medical care for religious reasons, all issue of medical control.

Pregnancy regulation is a relatively new social issue. Few people have had occasion to think in terms of who should make decisions about a pregnant woman's behavior. When asked to make a decision, people think in terms of some framework that is familiar and trusted. Faith in medicine is a framework most people are

comfortable with and one that "fits" issues of pregnancy and childbirth.

The findings indicate that men are more likely to endorse regulating a woman's behavior during pregnancy. Men are more likely than women to view pregnancy and childbirth as "mysterious" medical events. Lacking knowledge about pregnancy themselves, men are more likely to accede control of the situation to someone they trust to be better informed about medical issues, the medical professional.

Evaluation of the Instrument

Overall evaluation of the research instrument was positive. The length was reasonable and people understood the questions. After the experience of conducting the study, I recognize a need for changes in two areas. The first is additional measures of medical control. The second is new questions about state regulation in matters of child abuse and neglect. The overwhelming support of state regulation of parents in matters of abuse or neglect may be a regional effect in the Knoxville sample but new questions might produce a better measure of attitudes toward state rights.

Evaluation of Schema Theory

The utility of schema theory as a means of predicting one attitude from knowledge of another attitude was not born out in this study. The status of pregnancy regulation as a new social issue may have played a part. We only form opinions on issues after we become aware of them. Gamson and Modigliani (1989) suggest many issues which do not affect us personally are actually part of an ambivalent schema. The shift to a "pro" or "con" schema only occurs when public attention and media coverage give the issue salience. As the public becomes more aware of pregnancy regulation, stronger attitudes may evolve, much as they have in attitudes toward abortion. At this time, issues of pregnancy regulation do not "cue" an abortion schema.

Applicability of Schema Theory to Other Social Issues

One merit of the current study is insight into early attitude formation about a potential social issue for the general population. A good deal of research focuses on the ties between attitudes and behaviors but little has been done previously to identify underlying dimensions in attitude formation about newly encountered phenomena.

The Future

A future research possibility suggested by the current study would be to ascertain attitudes toward pregnancy regulation of people in other regions of the country. Pregnancy regulation has the potential of evolving from a social issue to a social problem. Future research might focus on the changes that occur in underlying dimensions of attitudes toward pregnancy regulation as the public become more knowledgeable about restricting women's behavior during pregnancy. Will abortion and pregnancy regulation become "linked" in the minds of the public over time? If so, will attitudes about pregnancy regulation polarize in the same manner as attitudes toward abortion, with supporting groups on both sides of the debate?

The importance of medical control in explanations of pregnancy regulation and court ordered pregnancy interventions suggest another direction for future research. Some legislation of prenatal behavior already exists. (Florida has a "drug delivery" law that has been used against a mother who used drugs during pregnancy and Illinois has a child abuse law that is automatically applied against mothers of children born drug dependent.) Media coverage of "crack babies" or infants born with fetal alcohol syndrome encourages public acceptance of

pregnancy regulation. What changes will occur in the law as pregnancy regulation becomes more acceptable?

A trend study is another possibility for future research. The focus would be whether attitudes toward pregnancy regulation and their determinants change as the issue becomes more visible through enactment of laws and judicial actions.

Currently, there is limited organized opposition to pregnancy regulation, although the A.C.L.U. and feminist organizations have identified it as a problem. The general public may not only not oppose regulation, they may see it as "good" (protecting unborn children) because it regulates the behaviors of "bad" women (i.e. drug users). The danger of regulating pregnant women lies with the message it sends to all those concerned with women's rights and individual rights in general.

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APPENDIXES

APPENDIX A. TELEPHONE SURVEY QUESTIONNAIRE

The following questions ask for your opinion about various family rights and responsibilities.

1. In your opinion, who has primary responsibility for deciding what type of education a child should receive? (Circle number)

1 STATE
2 PARENTS
3 OTHER (SPECIFY) _____

2. For each of the following topics, indicate whether in your opinion the topic should be taught primarily:

1 IN SCHOOL
2 AT HOME
3 IN CHURCH
4 SHOULD NOT BE TAUGHT

_____ Birth Control
_____ Sexual Relationships
_____ Abortion
_____ Religion

3. Should parents be notified if their unmarried female child under 18 tries to get birth control pills or devices. (Circle number)

1 ALWAYS
2 ALMOST ALWAYS
3 OCCASIONALLY
4 ALMOST NEVER
5 NEVER

4. In your opinion, who has the principle responsibility for the health care of children? (Circle number)

1 STATE
2 PARENTS
3 DOCTORS
4 OTHERS (SPECIFY) _____

5. Do parents have the right to refuse medical treatment for their children for religious reasons? (Circle number)

1 ALWAYS
2 ALMOST ALWAYS
3 OCCASIONALLY
4 ALMOST NEVER
5 NEVER

6. For each of the following situations, indicate which statement best describes your opinion of the state's role:

1 STATE SHOULD HAVE COMPLETE CONTROL
2 STATE SHOULD BE MORE INVOLVED
3 NOT SURE
4 STATE SHOULD BE LESS INVOLVED
5 STATE SHOULD NOT BE INVOLVED AT ALL

_____ The removal of children from abusive homes.

_____ The removal of children from homes where they are neglected.

(Now I would like to ask you a few questions about your attitudes about medicine and doctors.)

8. On the whole, how satisfied would you say you are with the honesty and standards of behavior of doctors in this country? (Circle number)

1 VERY SATISFIED
2 SOMEWHAT SATISFIED
3 OCCASIONALLY SATISFIED
4 SOMEWHAT DISSATISFIED
5 VERY DISSATISFIED

9. Overall, how much do you trust your (family/personal) doctor's medical judgment? (Circle number)

1 ALWAYS TRUST
2 TRUST MOST OF THE TIME
3 SOMETIMES TRUST/SOMETIMES DISTRUST
4 DISTRUST MOST OF THE TIME
5 ALWAYS DISTRUST

10. For the questions below, which of the following best reflects your opinion:

- 1 ALWAYS
- 2 ALMOST ALWAYS
- 3 OCCASIONALLY
- 4 ALMOST NEVER
- 5 NEVER

_____ Do people have the right to refuse medical treatment for themselves even when the doctor orders it? (The choices are always, almost always, occasionally, almost never, never.)

_____ Do you follow your doctor's advice?

_____ In your opinion, how often are doctors right about medical diagnosis?

_____ If a doctor considers certain medical tests necessary does the doctor have the right to require the patient to have those tests?

_____ If a female is pregnant, should a doctor be able to require that she have certain prenatal tests? (Always, almost always, occasionally, almost never, never)

_____ Do doctors have the right to require a pregnant woman to undergo medical treatment to benefit her fetus?

_____ Do doctors have the right to require a pregnant woman to undergo surgical delivery of her baby against her will?

11. If doctor and patient disagree about the proper treatment for the patient, whose opinion should decide the outcome? (Circle number)

- 1 DOCTOR
- 2 PATIENT
- 3 PATIENT'S FAMILY
- 4 THE COURTS
- 5 OTHER (SPECIFY) _____

12. For each of the following behaviors, please tell me how likely you believe it is that birth defects could happen if a pregnant woman does any of these things:

- 1 VERY LIKELY
- 2 SOMEWHAT LIKELY

- 3 NOT SURE
- 4 SOMEWHAT UNLIKELY
- 5 VERY UNLIKELY

_____ Exercises strenuously
_____ Fails to eat properly
_____ Smokes cigarettes
_____ Drinks alcohol
_____ Uses drugs

(Now I would like to ask you some questions concerning your opinions about the control government has over peoples lives in general.)

13. How do you feel about the amount of power government has over people's lives these days? (Circle number)

- 1 GOVERNMENT HAS TOO MUCH POWER OVER PEOPLE'S LIVES
- 2 GOVERNMENT HAS ABOUT THE RIGHT AMOUNT OF POWER
- 3 GOVERNMENT DOES NOT HAVE ENOUGH POWER OVER PEOPLE'S LIVES

14. In general, to what extent do you agree or disagree with the following statements? Would you say you:

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE
- 3 NEITHER AGREE NOR DISAGREE
- 4 SOMEWHAT DISAGREE
- 5 STRONGLY DISAGREE

_____ The state has a responsibility to protect children from possible harm from their parents.
_____ Parents who abuse their children should be subject to criminal charges.
_____ The government has a responsibility to stop women from engaging in behavior that endangers their unborn babies.
_____ Women whose babies are harmed by their failure to follow doctor's orders during pregnancy should be subject to criminal charges.

(The following questions ask for your opinion about medical issues that involve legal and ethical considerations.)

15. To what extent do you agree with the following statements: (Indicate one number for each statement)

- 1 ALWAYS
- 2 ALMOST ALWAYS
- 3 NOT SURE
- 4 ALMOST NEVER
- 5 NEVER

_____ People dying of incurable, painful disease should be allowed to end their lives before the disease runs its course.

_____ When a person has a disease that cannot be cured, doctors should be allowed by law to end the patient's life by some painless means if the patient requests it. (The choices are always, almost always, not sure, almost never, never)

_____ When a severely retarded infant is born with other defects that will kill that child unless surgery is performed, should the baby's parents be able to refuse that surgery?

16. Who should have the final say about whether heroic efforts are made to revive a dying child? (Circle number)

- 1 DOCTOR, HOSPITAL OR OTHER MEDICAL AUTHORITY
- 2 STATE BY MEANS OF COURT SYSTEM
- 3 PARENTS OF THE CHILD
- 4 OTHER (SPECIFY) _____

17. The next group of questions deal with your opinions about abortion. Please indicate whether you agree or disagree with the following statements.

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE
- 3 NEITHER AGREE NOT DISAGREE
- 4 SOMEWHAT DISAGREE
- 5 STRONGLY DISAGREE

_____ A woman should be able to obtain an abortion if she wants it.

_____ A woman should be able to obtain an abortion if she is married and doesn't want any more children.

_____ A woman should be able to obtain an abortion if she is not married and does not want to marry the man.

_____ A woman should be able to obtain an abortion if her family has very low income and cannot afford any more children.

_____ A woman should be able to obtain an abortion if

she is pregnant as the result of a rape.

_____ A woman should be able to obtain an abortion if there is a strong chance of a serious defect in the baby.

_____ A woman should be able to obtain an abortion if her health is seriously endangered by a pregnancy.

18. Indicate to what extent you agree or disagree with the following statements. The choices are:

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE
- 3 NOT SURE
- 4 SOMEWHAT DISAGREE
- 5 STRONGLY DISAGREE

_____ A husband should be notified if a wife is seeking an abortion.

_____ A husband should have the right to prevent his wife from getting an abortion.

_____ An unwed father should be able to stop his girlfriend from obtaining an abortion.

_____ A female under 18 should be required to get her parent's permission before she can get an abortion.

19. How personally concerned are you about the abortion issue? (Circle number)

- 1 VERY CONCERNED
- 2 SOMEWHAT CONCERNED
- 3 NOT SURE
- 4 NOT VERY CONCERNED
- 5 NOT AT ALL CONCERNED

20. For the statements below, which of the following best reflects your opinion:

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE
- 3 NEITHER AGREE NOR DISAGREE
- 4 SOMEWHAT DISAGREE
- 5 STRONGLY DISAGREE

_____ Children need stronger parental guidance, supervision and discipline than can be given when both parents work.

_____ When both parents work, children are more likely

to get into trouble.

_____ Even when they don't work, parents today don't give their children the time and attention they need.

_____ It would be a good thing for families if schools provided more care before and after school hours.

_____ It would be a good thing for families if there were more day care centers and other child care services outside the home.

_____ Whenever possible, women should stay home if they have young pre-school children.

_____ While there are some exceptions, the statement that "woman's place is in the home" still makes sense.

_____ It is more important for a wife to help her husband's career than to have one herself.

21. How do you feel about the following statement: Men are best suited to the public world of work and women are best suited to care for home and family. (Circle number)

- 1 STRONGLY AGREE
- 2 SOMEWHAT AGREE
- 3 NOT SURE
- 4 SOMEWHAT DISAGREE
- 5 STRONGLY DISAGREE

(Now I would like to ask you some questions about your opinions of religion and its importance to you.)

22. To what extent, if at all, has religion in your home strengthened family relationships? (Circle number)

- 1 A GREAT DEAL
- 2 SOMEWHAT
- 3 NOT SURE
- 4 A LITTLE
- 5 NOT AT ALL

23. How important would you say religion is in your life? (Circle number)

- 1 VERY IMPORTANT
- 2 SOMEWHAT IMPORTANT
- 3 NOT SURE
- 4 NOT VERY IMPORTANT

5 NOT AT ALL IMPORTANT

24. How often do you attend religious services? (Circle number)

- 1 DAILY
- 2 SEVERAL TIMES A WEEK
- 3 EVERY OR NEARLY EVERY WEEK
- 4 1-3 TIMES A MONTH
- 5 SEVERAL TIMES A YEAR
- 6 1-2 TIMES A YEAR
- 7 NEVER ATTEND

(Finally, I need some information about you personally.)

25. Regardless of the political party you identify with, do you lean more toward the liberal side or the conservative side politically? (Circle number)

- 1 STRONG CONSERVATIVE
- 2 SOMEWHAT CONSERVATIVE
- 3 MIDDLE OF THE ROAD
- 4 SOMEWHAT LIBERAL
- 5 STRONG LIBERAL

26. If you were asked to use one of four names for your social class, which would you say you belong to? (Circle number)

- 1 THE LOWER CLASS
- 2 THE WORKING CLASS
- 3 THE MIDDLE CLASS
- 4 THE UPPER CLASS

27. What is your family's average yearly income? (Circle number)

- 1 UNDER \$10,000
- 2 \$10,000 - 19,999
- 3 \$20,000 - 29,999
- 4 \$30,000 - 39,999
- 5 \$40,000 - 49,999
- 6 OVER 50,000

28. What is your sex? (Circle number)

- 1 MALE
- 2 FEMALE

29. How much formal education have you completed? (Circle number)

- 1 GRADESCHOOL
- 2 SOME HIGH SCHOOL
- 3 HIGH SCHOOL
- 4 2 YEAR COLLEGE
- 5 BUSINESS SCHOOL
- 6 COLLEGE
- 7 ADVANCED DEGREE

30. What is your age?

31. What is your marital status? (Circle number)

- 1 MARRIED
- 2 SINGLE (WIDOWED)
- 3 SINGLE (DIVORCED)
- 4 SINGLE (NEVER MARRIED)

32. Which of the following best describes your occupation?

- _____ Professional or technical
- _____ Manager, official or proprietor
- _____ Clerical
- _____ Sales worker
- _____ Craftsman or foreman
- _____ Operative
- _____ Private household worker
- _____ Laborer
- _____ Homemaker
- _____ Retired
- _____ Unemployed

33. Are there any comments or statements you would like to make about these issues?

THANK YOU VERY MUCH FOR YOUR COOPERATION

APPENDIX B. LETTER MAILED TO SAMPLE

Dear _____

Most people have beliefs about when individuals have the right to make their own decisions. We in the Sociology Department at the University of Tennessee want to know how you feel about the roles of government, doctors, and families in decisions. Within a week or so, you will receive a telephone call from one of our research team as part of a city-wide survey. Your participation in this survey will help us understand the feelings of citizens about these issues and we believe your feelings are important.

We are writing in advance of our phone call because we have found that many people appreciate being advised that a research study is underway and that they have been chosen in the research sample. You are one of a small number of people being asked to give their opinion on these issues. Your name was drawn in a random sample of the entire population of Knoxville. Your participation in this study is very important in order for the results to truly represent the citizens of this area.

The interview should only take about fifteen minutes. If by chance we call at an inconvenient time, please tell the interviewer and we will be happy to call back later.

Your answers will be confidential. Your name will never be placed on the questionnaire and results of the research will be reported collectively. You may refuse to answer any question you are uncomfortable with. Your help and that of others being asked to participate in this effort to find out about current attitudes is essential to the study's success. Please allow us a few minutes of your time when we call or ask us to call back.

If you have any questions, please don't hesitate to ask our interviewer. Or, you may contact me by phone at 974-6021 or by mail.

Sincerely,

Judy C. Plummer
Project Director

VITA

Judy Vaughan Plummer was born in Jerusalem, Arkansas on December 6, 1940. She attended elementary schools in Russellville, Arkansas and was graduated from Russellville High School in May, 1958. In January of 1980 she entered Arkansas Tech University at Russellville, Arkansas and in June of 1983 she received a Bachelor of Arts degree in Sociology. In the fall of 1983 she accepted a teaching assistantship at The University of Tennessee, Knoxville. She was awarded a Master of Arts degree in Sociology in December, 1985.

The author accepted a one year faculty appointment at the University of Central Arkansas in Conway, Arkansas. She returned to the University of Tennessee, Knoxville as a graduate associate in the spring of 1988 and was awarded the Doctor of Philosophy with a major in Sociology in December of 1989. She is currently a member of the Sociology/Social Work faculty at Appalachian State University, Boone, North Carolina.

In April, 1983, the author presented a paper entitled "Juvenile Drinking Behavior in Wet and Dry Counties" at the Arkansas Undergraduate Sociology Symposium in Conway, Arkansas. In August, 1985, she presented a paper entitled

"Adolescent Suicide: Social Definitions of a Social Problem, 1953-1982" at the American Sociological Association meetings in Washington, D.C. In the fall of 1986, the author presented a paper entitled "Failed Co-optation: the Move to Medicalize Adolescent Suicide" at the annual meeting of the Arkansas Sociological and Anthropological Association in Fayetteville, Arkansas. A paper entitled "Pregnancy Regulation: Who Protects the Mothers" was presented by the author in August, 1988, at the Sociologists for Women in Society at Atlanta, Georgia.

The author is a member of the American Sociological Association, Sociologists for Women in Society, the Southern Sociological Society and the Society of Honors Students of the American Sociological Association.