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PSYCHOLOGICAL CHARACTERISTICS OF WOMEN OPTING FOR PREMATURE TERMINATION OF PREGNANCY

SILVIA-CARMEN, MIKULOVIĆ[a], STELIANA, RIZEANU [a]
[a] *Hyperion University, Faculty of Psychology and Educational Sciences*
Department of Psychology

Abstract

Since 1990, with the legalization of abortion on demand, uterine curettage has become the contraceptive method commonly used in Romania, over a period of 10 years. Abortion on demand has long been a topic of concern among researchers, and little is known about its psychological consequences. Controversies regarding abortion and psychological consequences are determined by two different perspectives on how to interpret the results of existing studies. The present research wanted to highlight certain psychological characteristics of pregnant women who opted for premature termination of pregnancy in Romania. The results of existing studies cannot be generalized to the entire population of women who decide abortion. Psychological characteristics such as anxiety, self-esteem and depression were investigated. The results of this research have shown that pregnant women who give up pregnancy are less anxious than previously thought. Depressive states can create unwanted pregnancies because of the inability of women to take responsibility, to take measures against procreation. Pregnant women with a high level of self-esteem are associated with a small number of on-demand situations.

Keywords: *abortion on demand, anxiety, depression, self-esteem.*

1. INTRODUCTION

Existing theories and research show that pregnant women go differently through the abortion procedure upon request. The specialized literature presents different results (Major, 2003). The researchers agree that more clinical studies and statistical analyzes are needed. Some research has shown that abortion on demand has psychological benefits and emotional sequelae are rare. If abortion is refused, the result is less satisfactory, as regrets and suffering frequently occur (Major et al., 2009).

Other research suggests that abortion harms women's mental health and that psychological counseling has positive effects, that stress after termination of

Corresponding author: Silvia-Carmen Mikulovic

E-mail address: psiho_rot@yahoo.com

pregnancy is often caused by delays in decision-making and non-empathic, hostile attitudes by medical staff (Speckhard & Rue, 1992). Brody, Meikle and Gerritse (1971), Niswander and Patterson (1967) and Niswander, Singer and Singer (1972) tested pregnant women who opted for abortion, before and after abortion, and found that they were depressed, restless, and impulsive compared to normal pregnant women. Because all women were married and many were at first abortion, the results were considered eloquent (Illsley et Hall, 1976). Brody suggests that the tasks were random, there were errors in planning and were the result of ignorance, rather than any psychological predisposition. A review of the scientific literature indicated that the relative risk of mental opting for a single abortion in the first trimester of pregnancy, does not have a greater impact on mental health than the impact of a full-term pregnancy (APA, 2008). Women who denied abortion are more likely to experience higher levels of anxiety, lower life satisfaction and lower self-esteem compared to women who have had an abortion. The report of the APA Task Force on Mental Health and Abortion concluded that "it is clear that some women experience sadness, pain, and feelings of loss after termination of pregnancy, and some experience clinically significant disorders, including depression and anxiety" (APA, 2008).

Studies have been conducted to investigate whether induced abortion was a risk factor for subsequent depression or other psychological disorders.

1. A study that was conducted in Sweden and included 1457 women who had an abortion had as main objective the correlations between abortion on demand and depression, anxiety and posttraumatic stress disorder (Lundell et al, 2013). They responded three to six months after the abortion: 742 women responded at three months and 641 women at six months. Posttraumatic disorder (SQ-PTSD), anxiety and depressive symptoms were evaluated. Anxiety and depressive symptoms were assessed by the Anxiety and Depression Scale – HADS (Zigmond & Snaith, 1983). The prevalence of PTSD and PTSS before abortion was 4.3% and 23.5%, respectively, with high levels of anxiety and depression. At three months, the corresponding rates were 2.0% and 4.6% and at six months, 1.9% and 6.1% respectively. Conclusions: few women developed PTSD or PTSS after abortion. Most did so because of traumatic experiences that are not related to induced abortion. The concomitant symptoms of depression and anxiety have been clinically significant and require attention and support.

2. Another qualitative study with 987 participants conducted in the United States by Coleman and her collaborators (2017) provides information on women's suffering after an abortion. Respondents were asked to describe the most significant positive and negative aspects of abortion history in an anonymous online survey. Less than one third identified personal benefits from abortions. Whether there is a high risk or not, many women who have had an abortion report a mixture of positive and negative feelings about the experience. These feelings fluctuate over time. The survey shows that 13% of respondents visited a mental

health professional before the first pregnancy and abortion, and 67.5% made such visits afterwards; 6.6% used prescription drugs for psychological health prior to the abortion experience, and 51% thereafter. This indicates that most of the respondents were psychologically healthy before the first abortion and that there was a significant increase in the use of mental health professionals and medicines after their abortions. Many professional studies focus on quantitative methodologies at the group level that usually fail to capture participants' deeper thoughts and feelings in relation to their abortions, but Coleman and her collaborators (2017) took a different approach, asking study participants to identify the deepest negative elements and also identify any positive aspects of their abortion experience. This study provides some scientific support for the huge evidence of the emotional distress many women suffer from after abortion.

3. A study conducted in Norway investigates whether induced abortion was a risk factor for subsequent depression (Pedersen, 2008). Induced abortion is an experience shared by a large number of women in Norway, but little is known about the possible social or psychological implications of the health of an induced abortion. The study was performed on a representative sample of women from the normal population (n = 768) with ages between 15 and 27 years. Results showed that young adult women who undergo induced abortion may be at increased risk for subsequent depression.

2. **OBJECTIVE AND HYPOTHESES**

2.1. OBJECTIVE

Establishing relationships between psychological characteristics (depression, anxiety, self-esteem) and the request for premature termination of pregnancy.

2.2. HYPOTHESES

Hypothesis 1: The increased level of anxiety is expected to negatively correlate with the request for premature termination of pregnancy.

Hypothesis 2: We suppose that there is a positive correlation between depression and the number of abortions.

Hypothesis 3: We estimate that the low level of self-esteem negatively correlates with requests for premature termination of pregnancy.

3. **METHOD**

3.1. PARTICIPANTS

280 pregnant women participated in this research, who asked for termination of pregnancy between the ages of 17-41 years. The average age was 29 years. The

level of education was from no education to pregnant women with higher education, (9% out of school, 11% with primary classes, 26% with 8 classes, 34% with vocational school, 18% with high school, 2% with higher education).

All participants had to meet the following inclusion criteria:

1. To be at least 13 years old.
2. To have started their sex life.
3. To live in Romania.
4. To be able to read in Romanian and to understand the questions and indications of the questionnaires.
5. To request the premature termination of pregnancy.
6. The pregnancy should not be the result of a rape.

Exclusion criteria: Pregnant women who requested a pregnancy termination for therapeutic reasons (the existence of diseases that make them incompatible with the pregnancy and from a legal point of view it is advisable to interrupt the pregnancy) and those who had more than 12 weeks of pregnancy were excluded.

3.2. INSTRUMENTS

Cattell's Anxiety Questionnaire (1967) aims to measure anxiety, a profound personality factor involved in psychosomatic pathology. It contains 40 questions referring to the two forms of anxiety: veiled and manifested by pathological signs, but also to the five subfactors:

- Q3 - the social self - shows the degree of motivation in integrating the individual behavior around a feeling of self, accepted, conscious and of the approved social standards. It is one of the major causes of anxiety. It shows the degree to which anxiety was linked to the characteristic structures and accepted social habits.
- C - the force of the ego - represents the ability to control immediately and to experiment in an adapted and realistic way.
- L - insecurity or paranoid tendency.
- O - the tendency towards guilt; self-accusation and anxiety combined; the feeling of anxiety and depression (caused by the pressure of the superego).
- Q4 - psycho-professional performance or ergonomic tension; anxiety is born of the pressure of aroused impulses and needs not met of any kind. Its level is manifested in the inclination towards emotionality, tension, irritability and nervousness.

The Cronbach's internal consistency coefficient for this instrument is 0.87.

Rosenberg Self-Esteem Test (Rosenberg, 1965) is probably the most commonly used and best known self-esteem instrument and is still in use today.

Beck Depression Inventory Depression Scale-BDI (Beck, Ward, & Mendelson, 1961) is a self-administered inventory comprising 21 multiple-choice questions, one of the most widely used tools for measuring depression severity.

In its current version, the questionnaire is designed for people over the age of 13, and is composed of items on symptoms of depression, such as hopelessness and irritability, perceptions such as guilt or the feeling of being punished, such as and physical symptoms such as fatigue, weight loss and lack of interest in sex.

3.3. PROCEDURE

Selection stage:

All patients had to answer certain questions to determine their eligibility. These questions were:

1. Is your pregnancy less than 12 weeks?
2. Are you registered with a family doctor specializing in chronic diseases?
3. Is there a therapeutic reason for requesting premature termination of pregnancy?
4. Is pregnancy the result of a sexual relationship accepted by you?

The confidentiality of the participants was permanently protected by assuring them that their answers will not be discussed in the salon. All questionnaires were numbered, no names were used and no additional information was requested that could have led to the identification of respondents.

The decision of the persons who refused to complete the questionnaires was respected and I did not insist.

4. **RESULTS**

The following results were obtained (see Table 1).

1. Negative correlation of average intensity between anxiety and number of abortions ($r = -0.407$, $p = 0.000$).
2. Positive correlation of reduced intensity between depression and number of abortions ($r = 0.318$, $p = 0.002$).
3. Negative correlation of average intensity between self-esteem and number of abortions ($r = -0.402$, $p = 0.000$).

Table 1. Pearson correlation

		Anxiety	Depression	Self-esteem
Number of abortions	Pearson Correlation	-.407	.318	-.402
	Sig. (2-tailed)	.000	.002	.000
	N	280	280	280

5. **CONCLUSIONS**

The increase in the number of women who opted for abortion is inversely proportional to the increase in anxiety level. This allows us to conclude that the women who participated in the research live in dysfunctional families and have a low degree of attention and responsibility in relation to the probability of becoming pregnant, this low responsibility being explained by their anxiety related to the daily existence.

The increase in the number of women whose depression score is high is associated with the increase in the number of abortions. Depressive states can create unwanted pregnancies because of the inability of women to take responsibility, to take measures against procreation (Steinberg, 2011).

A high level of self-esteem is associated with a small number of situations in which women have encountered the phenomenon of abortion. From the point of view of self-esteem, it is observed that there is a negative correlation of medium intensity, statistically significant, which makes us conclude that self-esteem does not correlate with the problematic evolution of pregnancy. Because abortion intervention is not unique in their lives (87.14% have a history of miscarriages) it is relevant for research and excludes the possibility of an "accident", which will not be repeated. The repeated abortions show us a model taken by "contagion" whereby all women belonging to a group will automatically adopt or copy, the same behavioral, thinking model and will react identically to the triggering causes of the "crisis".

Abortion has been found to contribute to anxiety and depression, at least for some women.

There is a strong consensus based on research that there are numerous risk factors that can be used to identify which women are most at risk for negative psychological disorders from one or more abortions (Hanschmidt et al, 2016; Horvath & Schreiber, 2017; Reardon, 2018; Thorp, Hartmann & Shadigian, 2003).

Research has shown that women who opt for abortion need to be informed about all possible complications, including psychological ones. Therefore, a fuller understanding of the emotional experiences of applicants and their preparation for abortion, including pre- and post-abortion counselling is needed (Baker & Beresford, 2009; Reardon, 2018).

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