The Unwanted Pregnancy in Adolescence

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The unwanted pregnancy in adolescence is a crisis during which the adolescent woman often seeks help from an agency or physician. Frequently the option chosen is termination by therapeutic abortion. This option should be offered in a nonjudgmental manner with an attempt to understand and monitor the adolescent's emotional status. Psychiatric consultation should be sought only under specific circumstances. An approach to counseling is described which will help the adolescent with unwanted pregnancy resolve this life crisis constructively.

During the past seven years, with the removal of legal restrictions on abortion, there has been a steady increase in the number of adolescents who seek therapeutic abortion for termination of unwanted pregnancy. Today's adolescent woman has the option of deciding the fate of her pregnancy in a confidential physician-patient relationship. This places her in the position of having to make a complex decision concerning her life when she has never before been legally permitted to do so. It is a crisis for the adolescent to deal with a pregnancy at a time in her life when she does not want to be pregnant and is not emotionally prepared to deliver and care for an infant. The resolution sought for this crisis is frequently termination of pregnancy by abortion. The physician, being the only person authorized to perform this abortion, is an important contact for the young woman emotionally as well as physically.

We have studied a population of over 150 adolescent women requesting counseling for unwanted pregnancy in a "free youth clinic" sponsored by a public agency. Based on this experience this paper will describe several specific problem syndromes and propose some guidelines for conducting the initial (and crucial) contact with these young women.

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Background

Physicians historically have had mixed feelings concerning their role in relation to women with unwanted pregnancy. Prior to 1960 many physicians felt that abortion was a violation of their hippocratic oath. Psychiatrists were fearful of serious emotional

sequelae. Studies by Ekblad in 1955,[1] Kummer in 1963,[2] and a review of the literature by Simon and Senturia in 1967[3] led to a reconsideration of the effect of abortion on women with unwanted pregnancy. This culminated in a statement by the American Psychiatric Association Committee on Psychiatry and the Law in 1969:

A decision to perform an abortion should be regarded as strictly a medical decision and a medical responsibility. It should be removed entirely from the jurisdiction of criminal law. Criminal penalties should be reserved for persons who perform abortions without medical license or qualification to do so. A medical decision to perform an abortion is based on the careful and informed judgments of the physician and the patient. Often psychiatric consultation can help clarify motivational problems and thereby contribute to the patient's welfare.[4]

In 1970 Wittington published an excellent report on the psychological effects of abortion on women, noting the inability of psychiatrists to predict which women would become emotionally ill if abortion were denied. He suggested that among the indicators of post-abortion emotional problems were feelings of guilt as well as such variables as hospital staff attitude to the patient during the abortion.[5]

In 1971 in the State of California, a Supreme Court decision on the rights of a pregnant woman resulted in the following decision concerning pregnant minors:

Minors may obtain therapeutic abortions under law without the necessity of parental consent. The court emphasizes the law does not order the physician to give an abortion but merely allows the physician to exercise his discretion to approve or disapprove minor's request without requiring her to obtain parental consent.[6]

In June 1974, the US Supreme Court failed to review a lower court ruling from Florida which substantially affirmed the 1971 California decision. It appears, therefore, that the legal right of adolescent women to abortion is without question in the United States.

A frequent syndrome has been remarked by physicians and counselors who work with adolescents who declare their pregnancy unwanted and seek termination. There is apparently a behavioral pattern of seeking pregnancy, having frequent intercourse without contraception, and declaring after conception that the pregnancy was "unwanted." In studies by Settlage et al[7] at USC-County Medical Center (and confirmed in our own experience) most of the pregnant adolescents had sufficient knowledge of reproduction, easily available contraception, and frequent sexual contacts for more than one year prior to conception. The explanations for apparently seeking conception, while not desiring pregnancy, are complex.

Deutsch described this phenomenon as a "compulsion resisting any interference from reality." She believed the unconscious conflict resulting in this behavior to be the young woman's attempt to reconstitute the earlier mother-daughter relationship in which the daughter was loved and taken care of. The male partner is the symbolic mother with whom the daughter wishes to recapture the earlier intimacy. Thus, the *conscious* sexual stimulation of the adolescent woman is intensified by the *unconscious* longing for the dependent, presexual intimate relationship with the mother.[8]

Studies have demonstrated that adolescents do not have any significant change in their emotional structure after abortion. In fact, they report feelings of relief after termination has occurred. In a study by Reyes, Falk et al with 41 adolescents (average age 15) who had abortions, 90 percent were found to be in better physical health, and 75 percent in the same or better emotional health, post-abortion.[9] Simon and Senturia reported that 67 percent of the young women in their sample had a "positive emotional response post-abortion."[3] Ford and Tedesco demonstrated an unaffected emotional state post-abortion.[10]

Perez-Reyes, Falk et al describe the following three typical profiles in their group:

Group I Very young, inexperienced, passive girl, who submits to intercourse under the pressure of an older persuasive male.

Group II Young girl who, in her attempt to form a heterosexual relationship, experiments with sex to reach intercourse before full knowledge, or full awareness of consequences.

Group III Adolescent with emotional problems starting in adolescence with a marked conflict with parents. She practices intercourse as a pathological pattern of behavior to fill unsatisfied emotional needs.

They conclude the focus should be on sex education, contraception, and in some cases, psychotherapy.[9]

In 1972 Pasnau suggested the following guidelines for psychiatric consultation in therapeutic abortion in order to minimize psychiatric complications and to maximize growth potential:

1. There should be no routine psychiatric consultation.
2. Indications for psychiatric evaluation:
   a. If the patient exhibits signs and symptoms of a major psychiatric illness, including psychosis, suicidal ideation, significant depression, or severe personality or behavior disorder.
   b. If the patient has a history of a previous postpartum psychosis.
   c. If the patient exhibits ambivalence over her decision and/or requests psychiatric assistance in discussing motivational issues.
   d. If the patient is passively compliant with the wishes of parents or spouse, but does not herself wish to have an abortion.
3. *All* patients should be seen in routine follow-up visits.

During the post-abortion period there is a transient grief reaction that takes place when the termination of pregnancy is accomplished. It is an important time to monitor the patient's emotional status and if significant emotional problems occur, or if the patient requests counseling, psychiatric consultation should be sought.[11]

In a more recent article, Marmor and Pasnau demonstrated the usefulness of psychiatric consultation in certain cases despite the current trend away from this practice.[12]

Our Experience

Based on our experience of counseling over 150 adolescent women over the past two years at a local "free youth clinic", we have identified several major types of situations. The following are examples of the three most common types of problems encountered in our clinical practice.

A. *"The Angel Syndrome."* This young woman is usually an attractive,

intelligent, high school student who has high academic achievements and frequently is quite popular with peers. Her initial reaction to the confirmation of her pregnancy is a statement such as: "My parents will be so shocked, they don't even know I smoke." "My father calls me his angel." "I can't tell them but maybe I will." Further history reveals a conscious discomfort with the parents' lack of recognition of sexual maturity and their insistence on retaining her as their angelic little girl. Although the abortion, which is frequently requested, can be obtained without parental knowledge the young woman often subsequently shares this information with her mother.

B. *"The Parent-Expectation Syndrome."* In these cases adolescents' responses are frequently focused on fantasized parental reaction such as: "My father will die." "My mother will kick me out." "My parents went through so much grief with my sister when she had her abortion. I can't do it to them again . . . they warned me not to get pregnant." A history may reveal the parents' preoccupation with the sibling abortion which, unconsciously, can be seen by the adolescent as an expectation for her to do the same. The termination is usually sought, without ambivalence.

C. *"The Unloved Syndrome."* The presentation of an extremely emotionally deprived adolescent is often quite different from the above. Abortion is frequently *not* sought in cases where the adolescent has a history of gross maternal deprivation and perhaps multiple "homes" during latency and adolescence. The biological father is usually no longer significant in the dynamics, and the young woman expresses strong feelings of finally receiving love from someone – the infant. "I will love the child and take care of it despite the problems." "I know what it is like to be unloved and I will not allow that to happen to my child." "Bill said he didn't mind if I became pregnant but then he split when he found out – I don't need him anyway."

In each of these typical syndromes, the first contact with the young woman may be the single most important factor in helping her resolve the crisis. Frequently, termination is not desired and the adolescent often delays her initial contact with the clinic until the pregnancy has advanced beyond the time for a simple abortion. If the professional can engage this young woman by facilitating her medical care, frequently a significant relationship can lead to counseling which can offer options and reality testing. The goal is to better prepare her for dealing with whatever outcome is decided upon, whether it be having an abortion by saline amniocentesis, placing the child for adoption, placing the child for foster care on an interim basis, living with the child in an extended family situation, or assuming full responsibility for the child as a single parent.

The number of adolescents seeking therapeutic abortion appears to be increasing. In a recent survey in our clinic, the number of adolescents seeking abortion increased from 27 percent of all women seeking abortions in 1967 to 36 percent in 1973.

Our experience does not support the theory of lack of knowledge of sex or unawareness of consequences as described by Perez-Reyes and Falk. With our patients in Groups II and III, a corrective experience resulted from the experience resulted from the experience of pregnancy and took place without psychiatric intervention.

Our clinical observations have demonstrated that 60 to 70 percent of adolescent women seeking termination of their pregnancy admitted thoughts of inability to conceive. The duration of their sexual exposure was frequently in excess of one year before conception. No attempts were made to utilize contraceptive materials despite their easy availability.

Proposed Guidelines for Initial Counseling

The goals of the initial contact should be: (1) To give the requested information without coercion or moral judgment; (2) To evaluate the emotional status, past and present; (3) To seek psychiatric consultation if indicated; (4) To arrange future contact, ie follow-up if abortion is granted; and (5) To establish rapport based on trust and confidentiality for future professional contacts. These goals are directed toward the resolution of the crisis while developing rapport with the patient based on understanding and trust in a confidential physician-patient relationship. The patient's desires and plans for her pregnancy should be explored together with the considerations of the medical, social, family, and legal reality.

On the basis of our experience, it is suggested that although some unconscious conflicts may lead to the unwanted pregnancy, the monitored experience of allowing the adolescent to choose the fate of her pregnancy, including termination, without mandatory assistance from parents or counselors can lead to the resolution of a crisis in her life, and, at the same time, facilitate her emotional growth. The resolution of some adolescent conflicts, including confirmation of reproductive ability, identity as a sexually active female in contrast to an "angel," and identity as someone who can be financially and socially independent from her family, facilitates separating from total dependency on the mother and father and aids in the development of individual identity as an adult. Based upon our experience and that of others, we suggest the following guidelines should be followed during the initial interview with an adolescent woman who is seeking "information" from a physician as to whether or not she is pregnant.

1. Honor the presenting request and proceed to obtain medical information rapidly. If the request is for confirmation of pregnancy, the laboratory tests and physical examination should be done. If the request is for alternatives to pregnancy, knowledge of the law and the three options (ie, continuation, termination, or placement) should be explained.
2. Share the results individually with the assurance of confidentiality and respect for patient's choices and fantasies.
3. If the result is positive, await a reaction. Listen to her plans, and offer knowledge of medical-legal alternatives. The law requires that the physician feel confident that the minor has requisite understanding and maturity to give an informed consent for any medical treatment, including a therapeutic abortion. Follow the fantasies of continuation or termination and compare with the reality.
4. If the decision is for termination with no indication of need for psychiatric consultation, proceed with her plan. Medical arrangements can be

made with emotional monitoring. If individual or peer group counseling, or other supportive services are requested the physician should facilitate such services. If ambivalence, coercion, or other indications are present, psychiatric consultation should be sought.

A full description of the medical procedure and method of obtaining such, including financial requirements, should be discussed as in any other "informed medical consent." A follow-up visit should be described as a routine required medical procedure.

5. If the patient elects to continue pregnancy this should be accepted with appropriate support both medically and emotionally. Financial support should be explored, as well as family assistance and physician support, to ensure proper medical care during pregnancy. The physician may offer to meet with others who are significant in the young woman's life, including parents, since disclosure of the pregnancy is unavoidable as gestation progresses. When the adolescent feels accepted, emotional support initially offered as concrete support and exploration of resources usually leads to counseling and/or psychotherapy. The physician should remind the patient of alternatives and specific time-related options such as saline induction or placement.

6. If the test and examination are negative, the physician should ask: (a) date of last menstrual period; (b) method of contraception, if used; (c) last sexual contact. The history might reveal frequent intercourse without contraception. The stated desire of the girl might well be abortion if pregnancy were confirmed. A negative test does not state she is not pregnant, but in fact her behavior assures high probability she will be or is in early pregnancy. This inconsistency of stated goals and behavior should be pointed out as a medical observation, avoiding coercion or lectures on morality. Counseling or contraceptive information can be offered at this time to eliminate fears of different types of contraception, or serve as education if indicated. Offer continuing care even if the patient refuses contraception!

Discussion

The adolescent in most communities is offered many contacts if she suspects pregnancy. She may call pregnancy counseling agencies whose telephone numbers are published in papers and, at times, broadcast on the radio. She may go to a "free youth clinic" or go directly to a clinic in a hospital which will, after confirmation of pregnancy, proceed with the therapeutic abortion.

In many youth agencies the adolescent will request pregnancy confirmation and be asked to give a urine specimen. She is then told to participate in a "peer group rap session" where the focus is on education and emotional exploration. The results of the pregnancy test are given only after the group session, individually or in the group. Frequently a physician does not see the young woman.

If she confirms her pregnancy at a hospital or clinic specializing in abortions, frequently she has the procedure and is discharged the same day. She has little contact with any one person, is not "emotionally monitored" and may not have a "follow-up" visit.

The dichotomy between "forced counseling" to rapid termination with no relationship leads to problems with possible emotional sequelae. The adolescent who feels she has been coerced to receive counseling or termination and contraception does not have an opportuinity to develop a morally nonjudgmental, confidential relationship and after the crisis is resolved, frequently does not return for further counseling. The counseling sessions, unwanted, may remove defenses that are allowing the young person to resolve her crisis and augment guilt in the process.

The other extreme, of offering no significant emotional monitoring, can overlook potential psychiatric problems and miss the opportunity to develop rapport with a professional that can be helpful post-abortion for further care or counseling.

Our experience in counseling adolescent women has shown that many seek to confirm their biological identity in an unconscious manner by testing out their reproductive potential. They also strive to loosen the intense emotional bonds that have brought love from family and transfer these attachments to individuals in their own generation. They seek financial independence and also identity in society. Once the individual has some recognition of her biologic change at her menarche, and is taking a more active role in society, she often looks for recognition and confirmation of these changes.

Pregnancy gives the young woman confirmation that she has reproductive potential and "all systems are present and functioning." She is able to develop self-esteem and individual growth as a person by deciding without coercion to seek termination of pregnancy in a society which also allows her to receive financial and medical aid as an individual, free from parents.

Thus, the crisis of unwanted pregnancy is only a catastrophe if termination is not possible. With the easy legal accessibility to termination, sexual identity, and financial independence (through County Assistance when eligible), recognition by significant others of sexual activity and maturity is accomplished in the process of solving the crisis. The transient grief reaction, due to the loss of the fantasy infant, should not be thought of as pathological guilt, but should not be ignored by the physician.

The added benefit of the experience of pregnancy and legal termination, is the opportunity for the adolescent to form a confidential nonjudgmental relationship with a professional which can later be utilized to ensure not only the prevention of pathological regression, but through guidance further growth toward individuality.

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