Shame and artificial abortion

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SHAME AND ARTIFICIAL ABORTION

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Summary

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This research endeavors to provide a thorough examination of the often underestimated but profoundly influential role of shame in the process of abortion decision-making. Despite its prevalence and the frequency of abortion procedures, conversations surrounding this topic remain clouded by stigma and societal taboos, which can significantly impact individuals' experiences and mental well-being. Through a meticulous analysis of existing literature and empirical data, this study aims to bridge the existing gap in understanding regarding abortion, elucidating the factors that influence individuals' decisions and the intricate emotional landscapes they navigate. Central to our investigation is the recognition of shame as a critical element in shaping attitudes towards abortion, both on individual and societal levels. By illuminating the complexities of this phenomenon, we advocate for the importance of destigmatization efforts, the provision of comprehensive mental health support, and the cultivation of supportive environments that foster open and empathetic dialogue about abortion. Ultimately, our research underscores the imperative of prioritizing the voices and experiences of those directly affected, with the aim of fostering a more compassionate and inclusive society where individuals can make informed reproductive choices free from the burden of shame and judgment.

Keywords: Abortion, Shame, Stigma, Mental Health.

Sažetak

Sram i namjerni pobačaj

Alisa Fejzić

Ovo istraživanje nastoji pružiti temeljitu analizu često podcijenjene, ali iznimno utjecajne uloge srama u procesu donošenja odluka o pobačaju. Unatoč njegovoj učestalosti i čestim postupcima pobačaja, razgovori o ovoj temi ostaju zasjenjeni stigmom i društvenim tabuima, što može značajno utjecati na iskustva pojedinaca i njihovo mentalno blagostanje. Kroz temeljitu analizu postojeće literature i empirijskih podataka, ovaj rad ima za cilj premostiti postojeću prazninu u razumijevanju pobačaja, razjašnjavajući složene čimbenike koji utječu na odluke pojedinaca i kompleksne emocije kroz koje prolaze. Središnji dio našeg istraživanja je prepoznavanje srama kao ključnog elementa u oblikovanju stavova prema pobačaju, kako na individualnoj tako i na društvenoj razini. Osvjetljivanjem složenosti ovog fenomena zagovaramo važnost destigmatizacije, te pružanje sveobuhvatne podrške mentalnom zdravlju i razvijanje okruženja koje potiče otvoren i empatičn dijalog o pobačaju. U konačnici, naše istraživanje ističe nužnost iznošenja stavova i iskustava onih koji su izravno pogođeni, s ciljem poticanja suosjećajnijeg i inkluzivnijeg društva u kojem pojedinci mogu donositi odluke o svom reproduktivnom zdravlju, bez tereta srama i osude.

Ključne riječi: Pobačaj, Sram, Stigma, Mentalno zdravlje.

Introduction

Artificial abortion is the deliberate termination of a pregnancy, most often performed during the first few weeks of pregnancy. Conversations about artificial abortion in our community are often stigmatized and shrouded in silence. However, there is a lack of concrete information regarding the number of individuals who undergo abortions and their experiences of shame throughout the process. This knowledge gap is what motivates our research. Understanding the numbers is crucial to comprehend the extent of the issue, but it is equally important to consider the human aspect. Abortion is not merely a medical procedure; it is a deeply personal experience influenced by societal attitudes and individual emotions, particularly shame. Our research is driven by the belief that every individual's story deserves to be heard and understood. We aim to shed light on the topic, which is often obscured by judgment and secrecy, by uncovering the realities of abortion in our community and examining how shame plays a role. Our goal is to create a supportive environment where individuals are acknowledged and accepted, regardless of their reproductive choices. Through this research, we hope to contribute to a compassionate and inclusive dialogue about abortion, honoring the unique journeys of each person involved. Above all, this is about people, and by amplifying their voices and experiences, we aim to make a positive impact in our community and beyond.

Artificial abortion is a common intervention and is safe when conducted using recommended methods and by trained professionals. Abortion rates have varied over time. Globally, from 2010 to 2014 there were an estimated 35 abortions per 1000 women aged 15-44 showing a decline from the rate of 40 abortions per 1000 women in the period of 1990-1994. Laws on abortion differ worldwide with developing countries having regulations. Despite these laws many women still resort to practices posing health risks. Ensuring access to abortion is vital for health based on supporting data. Legal frameworks should prioritize availability as regions with access tend to have higher rates of unsafe procedures leading to more deaths and health issues. Both surgical and medication-based methods are safe and effective for abortion backed by data confirming their success rates. Diagnosis of abortion should be based on evaluation rather than solely relying on ultrasound results according to current evidence. Preventing abortion, a major cause of mortality is largely achievable through safe practices backed by data. Providing contraception after an abortion, along with education, has proven effective in reducing pregnancies, as shown by various studies and interventions.(1) Shame stemming from social backgrounds can lead to unsafe procedures being pursued in these situations. Also,

countries with highly restrictive abortion laws experience a significantly higher proportion of unsafe abortions compared to those with less restrictive laws. Such unsafe abortions contribute to a high number of maternal deaths, exceeding 80,000 annually in Iran. Some developing nations have strict laws against intentional abortion, except for specific circumstances due to cultural and religious convictions. In these countries, providing support and services to women facing unwanted pregnancies appears to be the optimal approach for reducing the incidence of illegal abortions. (2) Many women suffer from emotional, psychological, and interpersonal challenges after having an abortion. These difficulties can include grief, depression, PTSD and relationship problems. Different models explain the dynamics of post-abortion syndromes, such as developmental, drive, object-relations and narcissism models. Guilt and shame have a significant impact on the development and concealment of post-abortion effects. Pastoral care and healthcare providers should be aware of these effects and offer effective support to women experiencing them. (3) There exists a plethora of complex reasons why individuals may choose to undergo induced abortion. Among these multifaceted factors are notable themes such as the absence of sufficient social support, precarious economic circumstances, and pervasive psychological struggles. The decision to seek abortion may often be intertwined with experiences of anxiety and depression, which can stem from a range of sources including financial instability, personal relationships, and societal pressures.

Furthermore, individuals facing the prospect of abortion may also struggle with complex emotional dynamics such as complicated grief, which may arise from various life circumstances including loss or trauma. Additionally, the decision-making process surrounding abortion may be further complicated by disturbances in interpersonal relationships, whether with partners, family members, or friends, but also lack of readiness to be a parent. (4) Seeking abortion services can pose challenges, such as the requirement to travel time constraints for accessing care and financial burdens linked to the procedure. These difficulties could put pressure on people. When faced with these obstacles individuals may find themselves inclined to seek support, from others even if those individuals do not necessarily approve of their choice to end a pregnancy. This involvement of unsupportive parties in the abortion decision-making process could exacerbate feelings of stress, anxiety, and emotional strain, thereby potentially contributing to adverse effects on their mental health and well-being. (5)

A research in Great Britain has shown that women who have multiple abortions tend to be older and have had more years of exposure to the risk of unintended pregnancy. The number of children a woman has also plays a role, with each additional child increasing the odds of

multiple abortions by 33%. The timing of births is also important, as women who have a birth before their first abortion are less likely to have subsequent abortions. In addition, women who have obtained multiple abortions are more likely to be Black and have left school at an earlier age. They are also more likely to live in rented accommodation, report an earlier age at first sexual experience, and have been less likely to use reliable contraception at sexual debut. They tend to have a greater number of lifetime sexual partners. The failure of effective contraception is a central factor in unintended pregnancies and subsequent abortions. Studies suggest that around 50% of women seeking abortions use modern contraception methods. Early sexual competency, contraceptive use at sexual debut, and contraceptive use with a new partner can impact subsequent contraceptive practices and indicate potential risk. While social deprivation does not clearly predict repeat abortions, proxy indicators such as housing tenure, ethnicity, and leaving school early may contribute to the complex relationship between deprivation, unintended pregnancy, and pregnancy decision-making. Many women who experience repeat abortions have a pattern of unintended pregnancy and abortion early in their reproductive lives, followed by a period of safe sexual practices and planned childbearing, and then another unintended pregnancy. Half of all second abortions occur within 41 months of the previous procedure, indicating that they are not extreme cases occurring later in reproductive years. (6)

Amid discussions on abortion, additional question stands out; do behavioral differences exist between individuals undergoing their first abortion and those seeking subsequent procedures? A more complex statistical analysis reveals that the two most important factors differentiating first-abortion and repeated-abortion patients are age and coital frequency-both of which are variables that reflect added exposure to the risk of unintended pregnancy. However, even when the six most important factors (age, coital frequency, the quality of the relationship, cohabiting status, hypochondriasis and insomnia) were considered most of the women who were having a repeated abortion could not be differentiated from the first abortion patients. These two groups of women are far more alike than they are different from each other, there is no evidence that repeated abortion patients are poor contraceptive users or have more psychological problems than first abortion patients. (7)

The termination of pregnancy (TOP) is a highly controversial and emotional issue influenced by politics, morals, and religion. While early literature suggested minimal negative consequences following TOP, recent studies have indicated that negative consequences may be more prevalent than previously believed. Additionally, it has been shown that attitudes of healthcare providers contribute to the negative psychological outcomes mentioned earlier. The

interaction between the patient and healthcare provider, including the level of support and empathy provided, plays a significant role in shaping the experience and potential psychological impact of TOP. Despite legislative changes and the promotion of non-judgmental attitudes among healthcare providers and indeed society as a whole, the experience of TOP remains contentious and difficult to study. Psychiatric sequelae such as depression and PTSD are not common, certainly not in the short term, but ambivalence with feelings of relief, guilt and anxiety before and after the procedure are common. Service providers should be alert to this and promote an empathic, safe and secure environment. (8)

These psychological burdens can significantly influence an individual's decision-making process and overall well-being, underscoring the importance of comprehensive support and access to compassionate healthcare services in such circumstances.

Hypothesis

Poorer psychological well-being, socio-economic support, and a greater sense of shame are correlated to more frequent decisions for artificial abortion.

Aims and purpose of the research

GENERAL AIM:

1. To examine whether there is a difference in the poorer psychological well-being, socio-economic support and greater sense of shame among women who decide to have artificial abortion compared to pregnant women that decide to keep the pregnancy

SPECIFIC AIMS:

1. To examine the association between shame and depression and artificial abortion
2. To examine the relationship between socio-economic support and shame and artificial abortion
3. To examine the association between shame and quality of life and artificial abortion

Methodology

The research was "case-control", interdisciplinary, prospective, and survey-based. It took place from February 2024 to February 2025 at the University Hospital Centre Zagreb, Department of Obstetrics and Gynecology. The survey aimed to explore the existence of shame, depression, and the level of life satisfaction and perceived social support among women who chose artificial abortion compared to pregnant women who opted to continue their pregnancies.

The required sample size had been calculated based on the results of papers related to depression among pregnant women due to the absence of published papers on the topic. According to these results, including differences in proportions and with study power conditions of 80%, $\alpha = 0.05$, and $\beta = 0.20$, it had been deemed necessary to collect about 50 test subjects in each group. Considering the incidence of artificial abortions and the minimal financial costs of the research, it had been planned to collect a sample size twice as large.

All participants were informed about the research, its objectives, methodology, and data confidentiality. The EISS scale (External and Internal Shame Scale) had been utilized to

examine feelings of shame, while Beck's Depression Inventory had been employed for assessing depression. The SWLS scale (Satisfaction with Life Scale) had been used to gauge life satisfaction, and the PSS scale (Multidimensional Scale of Perceived Social Support) had been employed to assess the perception of social support.

Surveys had been distributed to participants upon their arrival at the Department mentioned, and to healthy women at the same health facility during regular check-ups, preferably at the first visit during early pregnancy stages. During the distribution of the surveys, the purpose and objectives of the research, as well as the methodology and data privacy measures, had been explained. Completion of the questionnaires had been considered as consent for participation in the research, eliminating the need for signing an informed consent form to avoid potential discomfort for the patients. All surveys had been completely anonymous and had no bearing on receiving equal treatment concerning patients' consent or non-consent to the research.

Inclusion criteria comprised pregnant women aged over 18 and under 45 years, with legal capacity, and without diagnosed psychiatric diseases or undergoing therapy for them. Exclusion criteria included minors, those lacking legal capacity, individuals with established severe somatic or mental illnesses, surveys where the veracity of the filled data could be justifiably doubted, or instances where there was information about interpersonal conflicts between the respondent and the staff at the institution conducting the research.

In addition to the data obtained from the aforementioned surveys, all relevant data related to the participants' health status, anthropometric measurements, perinatal data, and income information had been collected.

The research posed no greater health risk to the participants than their everyday lives. All scales used in the research had been translated into Croatian, were freely available for use, and had been validated. Validation data were accessible in relevant biomedical databases. All data collected through the research had been entered into a secure database accessible only to the principal researcher and mentors. Participant names did not exist in the database as all questionnaires were anonymous. Survey questionnaires had been securely stored in a locked cabinet, with only the main researcher having access. Furthermore, data had never been shared with third parties. Data collection had adhered to positive research practices, respecting all relevant laws and ethical principles inherent in this type of research, as detailed in the supporting documentation signed by the participants.

Results

In the final analysis of the results, 49 participants were included, of which 23 were in the control group (group of participants wishing to continue the pregnancy) and 26 were in the experimental group (group with abortion).

There were no age differences between the groups, as shown in Table 1.

Table 1. Age analysis of participants by group

	Group	Median	Minimum	Maximum	Z	P
Age (y)	Control	32	23	38	-0.645	0.519
	Study	33	19	40		

C – median; Z – test value (Mann-Whitney); P – statistical probability

No difference in marital status was found between the groups of participants. Table 2 shows the proportions of marital status according to the groups.

Table 2. Analysis of marital status among participants

			Group	
			Control	Study
Bračno stanje	Single	N	0	2
		%	0.0%	100.0%
	In a relationship	N	4	3
		%	57.1%	42.9%
	Married	N	15	16
		%	48.4%	51.6%
	Unmarried cohabitation	N	3	4
		%	42.9%	57.1%
	Divorced	N	0	2
		%	0.0%	100.0%

Pearson $\chi^2 = 3.848$; P = 0.427

No difference was found in employment status between the groups of participants (Table 3) nor in the level of education (Table 4).

Table 3. Employment status among groups of participants

			Group	
			Control	Study
Employed	Yes	N	19	21
		%	47.5%	52.5%
	No	N	3	6
		%	33.3%	66.7%

Pearson $\chi^2 = 0.596$; P = 0.440

Table 4. Education level among groups of participants

			Group	
			Control	Study
Level of education	Three-year vocational education	N	6	2
		%	75.0%	25.0%
	Four-year and higher secondary education	N	11	16
		%	40.7%	59.3%
	Professional study	N	2	2
		%	50.0%	50.0%
	University undergraduate study	N	0	3
		%	0.0%	100.0%
	Graduate study	N	3	4
		%	42.9%	57.1%

Pearson $\chi^2 = 5.617$; P = 0.230

Comparing the data on children from previous pregnancies, no statistically significant difference was found between the participants (Table 5).

Table 5. Analysis of previous pregnancies between participants

			Group	
			Control	Study
Do they have children?	Yes	N	15	23
		%	39.5%	60.5%
	No	N	7	4
		%	63.6%	36.4%

Pearson $\chi^2 = 2.013$; P = 0.156

No difference was found in the frequency of previous spontaneous miscarriages among participants (Table 6).

Table 6. Difference in frequency of spontaneous miscarriages among participants

			Group	
			Control	Study
Previous spontaneous miscarriages	Yes	N	8	7
		%	53.3%	46.7%
	No	N	14	20
		%	41.2%	58.8%

Pearson $\chi^2 = 0.622$; P = 0.430

There was no difference in the frequency of artificial abortions prior to the current pregnancy, as shown in Table 7.

Table 7. Difference in the frequency of previous artificial abortions

			Group	
			Control	Study
Previous artificial abortions	Yes	N	4	4
		%	50.0%	50.0%
	No	N	18	23
		%	43.9%	56.1%

Pearson $\chi^2 = 0.101$; P = 0.751

Among a total of eight participants with a previous abortion, there was an equal distribution of surgical and medical abortions between the groups.

Table 8 presents the results of the analysis of various questionnaires related to symptoms of depression (BDI), shame (EISS), perceived social support (PSS), and life satisfaction (SWLS). As evident from the table, the only statistically significant difference was found in symptoms of depression. The group of participants who decided to continue the pregnancy had a lower median in the Beck's Depression Inventory.

Table 8. Analysis of questionnaires for depression, shame, perceived social support, and life satisfaction among participants

	Group	C	25. P.	75. P.	Z	P
Beck	Control	8	6	10	-2.445	0.014
	Study	10	8	15		
EISS	Control	7	4	12	-1.451	0.147
	Study	9	6	17		
PSS	Control	4.9	3.7	6.3	-0.694	0.488
	Study	4.8	3.9	5.7		

SWLS	Control	26	22	30	-1.423	0.155
	Study	23	19	27		

C – median; 25. – 75. P – percentile; Z – test value (Mann-Whitney); P – statistical probability

There was no difference in categorical variables among the participants regarding BDI (Table 9), PSS (Table 10), and SWLS (Table 11).

Table 9. Analysis of BDI categories among participants

			Group	
			Control	Study
Beck category	Normal	N	18	15
		%	54.5%	45.5%
	Mild mood disturbance	N	2	7
		%	22.2%	77.8%
	Borderline clinical depression	N	1	3
		%	25.0%	75.0%
	Moderate depression	N	1	1
		%	50.0%	50.0%
	Severe depression	N	0	1
		%	0.0%	100.0%

Pearson $\chi^2 = 4.588$; P = 0.322

Table 10. Analysis of PSS categories among participants

			Group	
			Control	Study
PSS category	Low social support	N	0	2
		%	0.0%	100.0%
	Moderate social support	N	12	14
		%	46.2%	53.8%
	High social support	N	10	11
		%	47.6%	52.4%

Pearson $\chi^2 = 1.709$; P = 0.425

Table 11. Analysis of SWLS categories among participants

			Group	
			Control	Study
SWLS category	Dissatisfied	N	0	1
		%	0.0%	100.0%

	Slightly dissatisfied	N	4	6
		%	40.0%	60.0%
	Slightly satisfied	N	6	11
		%	35.3%	64.7%
	Satisfied	N	7	8
		%	46.7%	53.3%
	Extremely satisfied	N	5	1
		%	83.3%	16.7%

Pearson $\chi^2 = 5.147$; P = 0.273

A significant and very strong positive correlation was found between depression and shame in the overall sample of participants (n = 49; r = 0.879; P < 0.001), as well as a significant negative correlation between depression and perceived social support (n = 49; r = -0.778; P < 0.001) and life satisfaction (n = 49; r = -0.526; P < 0.001).

A significant negative correlation was also found between shame and perceived social support (n = 49; r = -0.810; P < 0.001) and life satisfaction (n = 49; r = -0.469; P = 0.001).

A small, positive correlation was found between perceived social support and life satisfaction (n = 49; r = 0.338; P = 0.018).

Shame and depression were slightly associated with a higher number of previous abortions (n = 49; r = 0.292; P = 0.042) and (n = 49; r = 0.285; P = 0.048), respectively.

Table 12 displays the analysis of the correlation between the previously described variables of depression, shame, perceived social support, and life satisfaction by groups of participants. The negative correlation between depression and life satisfaction was more pronounced in the group of participants with abortion, as well as the negative correlation between shame and life satisfaction. There was no correlation between perceived social support and life satisfaction in the control group, while this correlation was significant in the experimental group.

Table 12. The difference between correlation coefficients concerning BDI, EISS, PSS, and SWLS among groups

		Control				Study group			
Variable		Beck	EISS	PSS	SWLS	Beck	EISS	PSS	SWLS
Beck	r		0.861	-0.771	-0.192*		0.904	-0.856	-0.691*
	P		<0.001	<0.001	0.391		<0.001	<0.001	<0.001
	N		22	22	22		27	27	27
EISS	r			-0.863	-0.092*			-0.804**	-0.637*
	P			<0.001	0.682			<0.001	<0.001
	N			22	22			27	27
PSS	r				-0.045*				0.683*
	P				0.842				<0.001
	N				22				27

*Significantly different between groups

Discussion

Abortion is a central issue in the cultural conflicts currently affecting many nations around the world.

To the best of our knowledge, this study is one of the first to explore the nuanced relationship between shame and abortion-related psychological outcomes in Croatia. This research addressed a significant gap in the literature by examining how cultural, societal, and individual factors interplay to influence the emotional experiences of those who have undergone abortions. Understanding the role of shame is particularly crucial in regions where abortion remains a contentious and stigmatized issue. By investigating these dynamics within the Croatian context, this study contributes valuable insights that can inform public health strategies, psychological support services, and policymaking aimed at mitigating the negative emotional impacts associated with abortion.

In the abortion debate, we typically anticipate two opposing sides. However, the reality is more nuanced, with various perspectives that must be clarified for meaningful discussion. The four main patterns of abortion attitudes are: Pro-choice (consistent support for women's right to choose), Conditional Pro-life (opposition to abortion except in traumatic circumstances), Conditional Pro-choice (support for choice with reservations about some elective reasons), and Pro-life (consistent opposition to abortion). (9) We developed this classification by analyzing the demographic based on their multidimensional attitudes toward abortion, including moral reasoning, gender roles, sexuality, and the importance of children and parenthood. The abortion debate is fueled by opposing worldviews (a set of assumptions about how the world is and ought to be organized), namely liberal and conservative. Liberals believe in granting individuals maximum freedom for self-development and self-expression, acknowledging their unlimited potential. Conservatives, on the other hand, view humans as inherently prone to selfishness and harm, and therefore advocate for external regulation, hierarchical structures, and service and restraint for personal development. Essentially, liberals prioritize individual goodness and importance, while conservatives believe in achieving goodness through communal context.

With this in mind, we can pose a question about each stance on sex. Given the wide variation in views on life, and considering that life fundamentally begins with sex, whether for procreation or for the experience itself, it is essential to explore these perspectives. At the conservative end, sex is seen as an expression of love between married couples and a means of

procreation. It is considered appropriate when there is a lifelong commitment and openness to the possibility of creating new life. People who adhere to this perspective oppose any sexual activity outside of marriage, including homosexual relations. On the other hand, the liberal end values sex for its pleasure, human connection, and intimacy. It is seen as potentially transcendent, dissolving boundaries between partners and providing a sense of infinite connection. Premarital sex is not only accepted but desired in this view, and it recognizes that sexual relationships can exist outside of traditional male/female partnerships.
Since we have clarified their stance on sex, it is now fitting to define their beliefs regarding abortion. Abortion can be opposed by those who engage in dichotomous moral reasoning because they believe it takes the life of an innocent human being. Pro-life advocates argue that an unborn baby is a being because it exists and is human due to having human parents. They contend that the choice for a pregnant woman is whether to have a live baby or a dead one, and that every abortion results in the death of an unborn baby. These arguments are convincing for those who reason absolutely, leading them to oppose abortion.
The connection between moral reasoning and attitudes towards abortion can be individually or socially created. In the context of social frame alignment, moral entrepreneurs successfully link absolute moral reasoning with opposition to abortion, as evidenced by persuasion literature on the matter.
On the other hand, for relative and utilitarian reasoners, these arguments are foreign and ineffective. Pro-choice advocates argue that personhood at conception is a religious belief and that there will never be a consensus on the definition of "person" or when abortion is morally justified. They argue that the absence of moral consensus necessitates leaving the abortion decision to the individual. Relative reasoners find this argument convincing, leading them to support legalized abortion. This connection can also be individually or socially created. Overall, different moral reasoning approaches result in contrasting attitudes towards abortion, and the importance of framing and alignment in shaping these attitudes cannot be ignored.

Additionally, since the beginning of time, abortion has been always mentioned with religion. But some results show that religion's primary impact on abortion attitudes is indirect. Only public religiosity has a direct impact on abortion attitudes. If the current model estimated direct effects only, religion's impact would be just one-fifth the impact found from the path model. (10) Although it plays a key role in the abortion debate, there are important variations within religious groups and between different religious traditions, denominations, and moral beliefs. Catholics tend to be less supportive of abortion compared to Protestants, Jews, and the

nonreligious. However, research also indicates that conservative Protestants in Latin America and the United States oppose abortion more than Catholics. In South Africa, Muslim individuals are found to be less supportive of elective abortion but more accepting of traumatic abortion compared to Christians. Furthermore, while the abortion discourse often centers around protecting the unborn, studies suggest that individuals who prioritize the moral foundation of Purity, which focuses on morality and spiritual purity, are more likely to oppose abortion than those who prioritize the moral foundation of Harm. These findings highlight the complexities and nuances surrounding religious affiliations and different types of religious beliefs concerning abortion. (9)

Overall, does this mean that abortion policies are actually a weapon in the battle over the separation of church and state? Religious conservatives try to blur the line by basing policy decisions on everything from emergency contraception to stem cell research on ideology and religion rather than science. But then again, if we leave it to the society to dictate the norms, would the politics be run by the population itself? (11)

Although the Catholic Church theoretically maintains a very strict stance on these rules, there is some deviation from this position in terms of better function and acceptance.

The senior minister at St Barnabas Broadway in Sydney's inner city, who has been in that position for six years, shares his concern about the lack of unmarried women seeking abortions or disclosing pregnancies at his church. He believes this indicates a problem within the church culture that leads to an increase in abortions. The minister acknowledges that many Christians view pregnancy as the beginning of a vulnerable human life and that abortion is seen as harmful and unjust. However, despite the church's stance against abortion, the statistics regarding the number of abortions in Australia and the demographics of his own church contradict the belief that church members do not seek abortions.

Data shows that women aged 20-29, precisely the demographic of his church, are the most likely to seek abortions. The minister suggests that the church's emphasis on abstinence before marriage does not prevent young people from engaging in premarital sex. He argues that this issue is not due to a problem with the church's ethical teachings but rather a failure of individuals to adhere to their own principles. The minister also highlights financial concerns, the fear of jeopardizing future plans, and the shame associated with unexpected pregnancy as reasons women choose to have abortions.

The minister criticizes the church for not providing a supportive and loving environment for women facing unexpected pregnancies. He attributes the fear of condemnation and rejection as

a major factor in women choosing to have abortions. He believes that the church's approach to sexual ethics inadvertently shames and alienates women, leaving them with nowhere to turn. The minister suggests that Christians on the Left often avoid discussing abortion in order to collaborate with secular or progressive groups on other issues, while those on the Right focus on making abortion illegal without addressing the need for support for single mothers.

Instead of criminalizing abortion, the minister argues that the church should focus on creating an environment where women feel supported and empowered to choose parenting. This includes addressing the culture of shame and hidden sin within the church and finding creative solutions beyond the limitations of secular society. The minister proposes a different approach, envisioning older families providing financial support to young unwed mothers while they pursue education or training, men taking responsibility for their actions and finding fulfilment in parenthood, and a reemergence of the Christian doctrine of adoption.

Ultimately, the minister believes that the church should embody grace and forgiveness, creating spaces where repentant individuals can find acceptance. He hopes that the church will celebrate the courage of every pregnant woman, regardless of marital status, and actively support and facilitate the birth of every child. The minister sees this as the church's calling and a manifestation of its true identity. (12)

As mentioned in the introductory part, many women experience long-term emotional, spiritual, psychological and interpersonal difficulties following abortion, including complicated grief, depression, post-traumatic stress disorder (PTSD) and relationship disturbances. The decision-making process for abortion can lead to emotional crises for women. These women often feel overwhelmed and unable to take responsibility for their situation. They may experience internal disorganization, relationship conflicts, and financial stress. To escape this difficult situation, they may choose abortion, using dissociative defense to make a seemingly rational but cold decision. However, after the procedure, these women may feel horror and guilt for aborting what they perceived as a living being. This guilt focuses on the action and its object rather than on the self. Guilt is a pro-social emotion, concerned with the impact of one's actions on others and may motivate confession, apology, or repair. However, when avenues for confession are blocked, and there is no one to apologize to, guilt can transform into shame.

Post-abortion guilt can be compared to complicated post-abortion grief, as they both involve

grief and can be invisible or considered abnormal. Confession is often thwarted, as society expects women to act as if nothing had happened. This can lead to personal expense and reluctance to disclose abortion history due to shame and guilt. However, disclosure is necessary for healing. Without confession, guilt can turn into shame, and speech is essential for resolving guilt and escaping shame.

The transformation from guilt to shame parallels the path from normal grief to complicated grief. In both cases, confession is hindered, and a lack of trust and openness with therapists can prevent disclosure. Silence perpetuates shame, and while speech alone may not be sufficient, it is necessary for resolution.

In summary, the decision-making process for abortion can lead to emotional crises for women, and the use of dissociative defense to make a rational but cold decision. After the procedure, guilt may arise, and when avenues for confession are blocked, guilt can transform into shame. Post-abortion guilt and grief can be similar, and both require disclosure for healing. Without confession, guilt and shame persist. Communication and openness are essential for resolving guilt and escaping shame. (13)

As we know, we do not live in a perfect and harmonized world. It is obviously evident that the development of the area and population have major influence on the decision-making regarding abortion. It has been determined that women’s stigmatizing attitudes, beliefs and actions towards abortion are high in a rural region with high fertility and results shows that state of development of the city, socio-cultural-fertility and structural characteristic of living area significantly affect the stigmatizing attitudes, beliefs, and behaviors towards abortion in women. (14)

This study underscores the importance of recognizing the relatively modest sample size, underscoring the necessity for meticulous consideration in interpreting the findings. Several limitations are noteworthy, including the absence of comprehensive data on participants' previous marital statuses. It's plausible that some participants might be in subsequent marriages, an aspect not captured in the study's parameters. Furthermore, while employment status was documented, other socio-economic factors, notably income, were not included in the analysis, potentially impacting the holistic understanding of the participants' backgrounds.

Additionally, the questionnaire did not explicitly probe participants regarding the specifics of their previous pregnancies, such as whether they were deemed pathological or the proximity between past miscarriages and the current pregnancy. These details, though relevant to understanding potential confounding variables, were not within the scope of the current investigation. Addressing these gaps in forthcoming surveys will be crucial for refining future research accomplishments.

It's also relevant to recognize the distinctive nature of the participant cohort under examination. This study involves a specific group, predominantly pregnant women, who are in a vulnerable state. In contrast, the control group stems from a hospital-based setting, reflecting a population predominantly seeking antenatal care for medical reasons.

Conclusion

In conclusion, our research highlights the profound impact of shame on individuals facing abortion decisions, correlating with increased depression and decreased life satisfaction. Additionally, significant negative correlations were found between shame and perceived social support/life satisfaction, while a small positive correlation existed between perceived social support and life satisfaction. Furthermore, shame and depression were slightly associated with a higher number of previous abortions.

Addressing shame surrounding abortion necessitates a multifaceted approach, including destigmatization efforts, tailored mental health support, and fostering supportive social environments. Prioritizing the voices of those directly affected is crucial in building a compassionate society where individuals can make informed reproductive choices free from judgment.

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Biography

Alisa Fejzić was born on September 18, 1998, in Sarajevo, Bosnia and Herzegovina. She completed her elementary school education in Sarajevo, where she also attended ballet and music school. During her high school years in Sarajevo, her interest in medicine and helping others led her to join the Red Cross volunteering organization and First Aid team. The commitment of the team paid off, as they secured first place in several competitions. Upon graduating from high school, Alisa pursued her interest in medicine by enrolling in Medical school in Sarajevo. and after completion of her first year transferred to School of Medicine, University of Zagreb. She participated in the Croatian Student Summit (CROSS), where she contributed as both a first and second author. Her work and research culminated in the publication of her abstracts in "Medicinska naklada", a medical journal.