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FAMILY HEALTH AND THE NATALITY AT THE DAWN OF THE 21th CENTURY. THE MENTAL HEALTH PROFESSIONAL'S AND SEXOLOGIST'S PERSPECTIVE

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The general trend of international decrease of natality could be recorded in Romania as well. Besides the common barriers in developped countries regarding the variable dynamics of the natality, explained also by a previous pronatalist policies, poor socioeconomic standard, adherence to social and religious norms, poor pregnancy monitoring, high infantile mortality, emphasis has been dedicated to the description of health isssues, psychological and mental health problems preexisting or triggered by fertility difficulties. Special attention has been dedicated to the influence of the Covid-19 pandemics on the natural growth. Finally, future directions and policies aimed at facilitating natural growth and sustaining active families in childbearing and child rising have been outlined and proposed.

Key words: Romanian natality within international context; somatic and mental health problems; future directions.

A BRIEF OVERVIEW OF THE ROMANIAN THE NATURAL GROWTH WITHIN THE INTERNATIONAL CONTEXT

There is a general trend in the decrease of birth rates in the last decades, irrespective of the development stage of the countries and the wealth of the couples or individuals. In spite being an individual's, couple's problem regarding the potential of childbearing intention and potential, it is strongly influenced equally by relational dynamics, health, adherence to social, religious norms, socio-economic conditions. Last centuries witnessed high natality rates; families had many children due to religious constraints, lack of knowledge of effective family planning strategies but the total fertility rate remained modest, especially due to high infant mortality rates.

The 60ties brought enormous changes in personal freedom of the practice of sexuality, liberated of the fear of undesired pregnancies, by launching the first contraceptive pills. Therefore, sexuality could be enjoyed without borders and constraints, within a stable couple, a nightstand or adulterous, changing it mainly from the reproductive to the recreative purpose. These came along with supplementary civil rights, women's emancipation, less religious influence and adherence to specific precepts and dogmas (prohibition of pre/extramarital sex, abortions, divorce, extramarital children, adoption of children by unmarried couples, singles or even by gay persons). The hippy movement encouraged common nurture of children, conceived during parties with unknown partners, with less parental bonding. The libertinage of these times, combined with excessive consumption of psycho-active drugs, promiscuous sexual intercourses raised later on the huge problem of HIV infection and other STD (sexual transmitted diseases), imposing the revalorization of the contraceptive methods, having as consequences safe sex but also birth control and family planning, constant decrease of natality. The analysis of fertility in developed countries could record the changes in fertility behaviors as a systematic adjustment to exogenous variables and the trend driven by

individualism as a rational fertility decision (Kohler, 2000).

The paradox that we are facing in the last two decades: the acceleration process triggers the earlier onset of menses, the precocious adolescence and sexual drive (precipitated partly by junk food, social pressure, and informational avalanche regarding the issue of sexuality), implicit the beginning of sexual intercourses; never the less, extending at the same time the educational process and carrier oriented equally in men and women, has a consequence the postponing of marriage and childbearing, or limit the number of children, although having good standard. As a consequence, the first planned pregnancy occurs over 30 years, even over 40 years, along with risks for miscarriage, fetal malformations, other possible side effects or difficulties, and earlier menopause.

DEMOGRAPHIC INDEXES RELEVANT FOR THE NATURAL GROWTH

Are natality, fertility indicators of the vigor of a nation, population? Demographical studies analyze different parameters that might indicate several aspects that health care systems and policy makers try to influence. As life expectancy rise constantly by adequate prevention and screening/curative methods, natality is still low, partly to postponing the conceiving age or due to infertility or to economic difficulties assumed in raising children. Romania is an European upper middle income country, with an average life expectancy of 75.1 years, considerably below the average Eu life expectancy of 80.9 years. On the other hand, extremely concerning are the still unsolved problems of the highest figures of infant and maternal mortality (Vlădescu *et al.*, 2016). An important epidemiological indicator is the natural growth, representing the report between healthy newborns to the deaths, following worldwide a descending curve, compensated partly in developed European countries by immigration (Jozwiak &Kotovska, 2008), but with concerning figures regarding this indice even before the Covid-19 pandemic for Romania in 2019 (-2,9‰) but with a dramatic drop during the first nine months of 2020 (-4,2‰) and first trimester of 2021 (-7.9‰) (MS, INSP, CNSISP 2021). Romania's birth rate in 2019 dropped at the lowest rate in 53 years (INSP, RNEP, cited by Insider 2020), 178,130 children being born. A similar low birth rate was recorded in 1966, one year before the release of the anti-abortion decree 770/1977.

A BRIEF HISTORY OF THE ROMANIAN PRONATALIST POLICIES AND THEIR CONSEQUENCES

In order to understand the actual natality situation, a brief overview of the history of the Romanian natality policies seems essential: there was a dramatic drop after the second WW due to scarce availability of men, economic crash and poverty, drought, leading to immigration of children into wealthier parts, high infant mortality, high levels of morbidities. Therefore, in order to restore natality, the recent installed communist regime, issued the first antiabortion law, within the article 482 of the Penal Codex in 1948.

But a decade later, in 1957, there was an attempt to relax many aspects of the oppression, among them the intimacy and support for families, access of women on the labor market, but modest housing facilities, cold apartments, interruptions in electric light provision. Therefore, low figures of natality growth from 24,2‰ in 1956 to 14,3‰ in 1966 (Berelson, 1979) determined Ceaușescu to initiate a pro natalist program and to ban libertinage, divorces. The aim was to attain the target of the national socioeconomic plan, that could be realized only by a population of at least 18 million inhabitants and increase towards 24–25 million inhabitants by the year 1990.The antiabortion decree 770/1966 prohibited the official abortions (being the main fertility control, other contraceptive methods being either unavailable or prohibited), limited only to life threatening situations, severe malformations, families with more than 4 children, women over the age of 45 (Decretul 770, 1966). A spectacular explosion of births has been recorded the following years, a baby boom, generation called "decreței" (Betea, 2012); this phenomenon attracted huge social consequences: the overwhelming necessities of nurseries, food shortage, and the crowded orphanages. In spite the initial baby boom, during the 70^{ties} women were forced to limit their childbearing potential by illegal abortions, associated with high levels of women mortality, childrens' malformations, overcrowded orphanages. In spite frequent random gynecological controls, women risked their health, freedom (the discovery of illegal abortion procedures was punished by imprisonment of both the pregnant woman and of those who initiated the procedure), life. In order to limit unwanted pregnancies, women applied empirical contraceptive methods as the calendar method or bought from the black market contraceptive pills or intrauterine devices. Even

though, the dangerous local abortive irritative substances or devices initiated in peculiar places the abortion of the fetus, lead often to accidents or fatality. Therefore, a tragic epidemiological index, that of maternal mortality rose up to 210‰, from the official deaths in hospitals. Besides these official registred death, were those occured in private places or suicides of pregnant single women (Jinga *et al.*, 2010).

SOCIO-ECONIMIC, PESONALITY FACTORS IMPLIED IN FERTILITY

A social problem of shortage of active population to sustain financial the growing aging population, demands couples, individuals to assure this generation gap. But for those who are expected to work, bear and raise children does the society offer enough safety, adequate climate, stimulative measures?

But this growth of natality within the social context and the medical achievements has to be understood by it's dynamics recorded during the last two centuries by the term demographic transition model (DTM): while during the first stages, in spite of high levels of birth, infant mortality atributable to fatal diseases, low sanitation, poverty, later on, mortality decreased by improved medical and social conditions but less persons were disposed to give birth to children by prioritisation of career, elevated social standards, attaining actually the fifth stage (Glowaki & Richmond, 2007). There is an increase burden regarding the caring facilities in developed countries.

The pertinent question is: why is natality decreasing especially in developed countries, where material prerequisites are stable and functional?

Women empowerment, their active implication in labor and career, concurrence dismisses or postpones childbearing, adoption (Glowaki & Richmond, 2007), gender role change, competition, social status, academic fulfillment, wealth, secularization, environmental concerns may influence negative natality (Skirbekk, 2008), as national natality bans driven by economic poverty, as the case of China.

Hence social environment, although more apparent family friendly and inclusive, might negative influence fertility rate: a decline of this parameter as urbanicity progresses, immigration as families live under stressful condition and stem their aspirations on higher standards and motivate the decision in regulation of family size (Martine *et al.* 2013).

Personal/ couple factors that might negatively influence fertility rates are: increased age, especially in women, in lesser degree in men decreases the child birth potential and size of the family, previously successful pregnancies, subfertility over three years will lessen the chances of a pregnancy, timing and frequency of sexual intercourses.

Life style might be also involved as weight (especially overweight, obesity but also underweight), smoking, caffeine, alcohol and psychoactive consumptions and abuse, but over the counter consumption of different drugs such as anti-inflammatory drugs, steroids, medical conditions (Chronopoulou *et al.* 2021).

The couple match and fertility intention in economic advanced countries is driven besides attractiveness, also by a constellation of social and economic, educational items especially, being recorded two phenomena that of the "income effect" and "price effect", highly dependent of the position on the labor market. As a consequence, any economic down drift will affect the intention to have and raise children (i.e. pregnant adolescents forced to drop out school in order to take care of the off springs (Salinas& Jorquera-Samter, 2021). Structural changes in welfare influence most of European developed countries in the decline of natality (Jozwiak &Kotovska, 2008). Postponement of chilbearing might be attibuted to the increased women education and economic autonomy, high status aspiration and foster of supplimentary jobs, competitive environment, freedom of choice, independency but also fear of separation (Lesthaeghe, 2001). To have a hint into the child birth fear, that may attend around 80% of women and the development of a vicious cycle of primary, secondary anxiety, fear acquisition by direct conditioning, vicarious experiences, transmission via proxy, cognitive beliefs and expectations (regarding fetal malformation or dangerous delivery), behavioral reactions (Rondung *et al.*, 2016), at the extreme being the dread of childbirth, called tokophobia (Bhatia & Jhanjee, 2012). As women are more conscious about their physical fitness and body image, pregnancy is seen as affecting their status.

Infertility, appreciated by WHO affecting 8–12% of couples, may ruin self-esteem, lead to stress, anxiety, depression, sexual disorders, conflicts, affecting individuals and the couple, deprivation of the experience of parenthood, sense of defective-

ness, incompetence, being subject of stigmatization by peers, family, society (Doyle & Carballedo, 2014). Perinatal mental health disorders reached in high income countries (HIC) 10-15% of women, developing severe depression in the first trimester after delivery, three times higher, while the situation in low and middle income countries (LMIC) are in the range of 10–41% (WHO, 2008). Even the fertility programs were problematic especially during the Covid-19 pandemic, limiting the access, raising various questions about the viability of the off springs, vertical transmission in case of contamination (Espositoa *et al.*, 2020).

MENTAL HEALTH DISORDERS AND FERTILITY

Childbearing potential of persons wih psychiatric disorders, especially in mood disorder and schizophrenia might be reduced even before treatment, being present in both genders, with aggravation as the disease progresses, especially in men (Baron *et al.*, 1982). It has been noticed that women diagnosed with mental health problems are rather single, with modest socio-economic level, smokers, with comorbid somatic diseases, low monitoring of pregnancies, less counseling. Deliveries occurred rather vaginal, with more days spent in hospitals, low breastfeeding. Newborns were small for their gestational age, lower Apgar scores, premature; stillbirth being also recorded (Sūdžiūtė *et al.*, 2020).

Roots of natality problem in schizophrenic patients are related to poor sexuality driven by the personality that is solitary, do not engage in mating behaviors, display low libido, anorgasmia. Moreover, after the onset of the disease, the divorce rates are high and the probability to find a new sexual partner is low.

Adjunctive, the metabolic effects of antipsychotics, especially in elevations of prolactine induced by Risperidone (represented by obesity, amenorrhea contribute to supplementary low fertility rates (Micluția *et al.*, 2008). Regarding bipolar disorder, it is well established that depressed persons display low libido, erectile dysfunction, and modest engagement in sexual practices; but even during manic or hypomanic episodes, partner search is intense but instability, less programming and pervasive teratogenic treatments negatively influence sexuality (Micluția *et al.*, 2019). Special alerts document the teratogenic effects of valproate acid, a mood stabilizer (Anmella *et al.*, 2019, Davies *et al.*, 2020, Kurvitsa *et al.*, 2020). Perinatal mood and psychotic disorders represent huge mental health problems, which affect the women, children nurture,families, and the future procreative intention (Xu *et al.*, 2016). Infertility seems to be a problem in dysthimia, anxiety (Klemetti *et al.*, 2010). A huge problem regarding fertility but also child malformations represent alcohol and psychoactive drugs (Baldur-Felskov *et al.*, 2013), affecting also the social status of the children, care, and education, besides neglect and abuses. Among personality disorders, schizoid, schizotypal, paranoid, dependent, anancastic, avoidant personalities are either solitary, suspicious, with poor esteem and avoid the mating process while antisocial, histrionic, narcissistic ones display intense, risky sexual behaviors, less interest in children's responsibilities (Micluția, 2021). A delicate issue regarding reproductive health is that of persons with mental retardation or diminished decision capacity, who should benefit of specialized support (Ross *et al.*, 2021).

FERTILITY DURING THE COVID-19 PANDEMIC

The Covid-19 pandemic outlined besides the medical threat and sanitary emergency, socio-economic down drift, with huge impact on families, limiting the mating process, by travel bans, postponing marriages and questioning the procreative potential due to limited knowledge about potential vertical transmission, uncertainties, economic crash, and unemployment lead to low natality scores in the last two years (Gromsky *et al.*, 2021). The majority of fertility treatments were suspended during the initial phase of the Covid-19 pandemics, causing anxiety, major distress, disagreement with the suspension strategy, frustration (Haham *et al.*, 2021).

FUTURE DIRECTIONS AND POLICIES AIMED AT FACILITATING NATURAL GROWTH AND SUSTAINING ACTIVE FAMILIES IN CHILDBEARING AND CHILD RISING

Taking into consideration the rather pessimistic situation of natality worldwide, coherent strategies should be employed in order to stimulate young persons to decide that parenthood might fulfill them concomitant with job and financial security.

Besides the social and financial support of families, impact studies and proactive state driven policies should overcome the generation gap. The Romanian pronatalist strategies, facing the phenomenon of emigration of young, qualified citizens, should be addressed within broader European and international frameworks; as focus are young working women, but also over 30 years, with several kids, balanced urban/rural provenience, attractive leaves for fathers, state implication in education and welfare, exceed the actual allocation within the NGP of 1–2%, tax reductions (Ghetau, 2012). Other measures entitle state support, part time jobs, enhancement of workplace flexibility, easing young persons to secure jobs, changing attitudes regarding single parents, policies that foster reconciliation between work and family, promotion of family friendly environment, decent housing and health services access, decrease of household expenditures, stimulative educational expenditures (OECD, 2019) along with coherent and pragmatic recommendations of WHO (WHO, 2008).

REFERENCES

1. Kohler, HP. *Social Interactions and Fluctuations in Birth Rates*. Population Studies, 2000, 54: 223-237.
1. Vlădescu, C, Scîntee, SG, Olsavszky, V *et al. Romania Health system review*. Health Systems in Transition. 2016, 18, 4:1-170.
2. Jozwiak, J &Kotovska, I E. *Decreasing birth rates in Europe: reasons and remedies*. European View.2008, 7:225–236.
3. Ministerul Sănătății, Institutul Național de Sănătate Publică, Centrul Național de Statistică și Informatică în Sănătate Publică. *Mișcarea Naturală a Populației*. Buletin Informativ. 2021 3: 1-12.
4. INSP, RNEP, cited by Insider 2020 Media: *Romania's birth rate drops to lowest level in 53 years in 2019*, Newsroom, Jan. 2020.
5. Berelson, B. *Romania's 1966 Anti-Abortion Decree: The Demographic Experience of the First Decade*. Population Studies, 1979, 33, 2, 209-222.
6. Consiliul de Stat al Republicii Socialiste România. *Decretul 770 din 1 octombrie 1966*, Monitorul Oficial.
7. Betea, L. *Decretul antiavort, prostituția și „Decreței"*. Adevărul.2012, 12 nov.
8. Jinga, L M, Soare, FS, Doboș, C, Roman, C. *Politica pronatalistă a regimului Ceaușescu, vol.II. Instituții și practici.* Editura Polirom, Iași.2010.
9. Glowaki, T, and Richmond, AK. *How government policies influence declining fertility rates in developed countries*. Middle States Geographer. 2007, 40:32-38.
10. Skirbekk, V. *Fertility trends by social status*. Demographic Research. 2008, 18, 5:145-180.
11. Martine, G, Alves, JE, Cavenaghi, S. *Urbanization and fertility decline: Cashing in on structural change*. IIED Working Paper. IIED, London, 2013.
12. Chronopoulou, E, Seifalian, A, Stephenson, J *et al. Preconceptual care for couples seeking fertility treatment, an evidence-based approach.* Fertil Steril Rev.2021,2:57–74.
13. Salinas, V, Jorquera-Samter, V. *Gender differences in high-school dropout: Vulnerability and adolescent fertility in Chile.* Advances in Life Course Research.2021.49, 100403.
14. Lesthaeghe, R. *Postponement and recuperation: recent fertility trends and forecast in six Western European countries*. Interuniversity Papers in Demography, IPD-WP 2001-1.
15. Rondung, E, Thomtén, J, Sundin, Ö. *Psychological perspectives on fear of childbirth*. Journal of Anxiety Disorders. 2016, 44: 80–91.
16. Bhatia, MS, Jhanjee, A. *Tokophobia: A dread of pregnancy*. Ind Psychiatry J. 2012, 21(2): 158–159.
17. Doyle, M & Carballedo, A. *Infertility and mental health*. Advances in psychiatric treatment. 2014, 20:297–303.
18. WHO.*Report of the WHO-UNFPA*. Geneva, 2008, 24 p.
19. Espositoa, V, Raniaa, E, Lico, D, *et al. Influence of COVID-19 pandemic on the psychological status of infertile couples*. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2020, 253: 148-153.
20. Baron M, Risch N, Mendlewicz J. *Differential fertility in bipolar affective illness*. Journal of Affective Disorders. 1982 2: 103–12.
21. Sūdžiūtė, K, Murauskienė, G, Jarienė, K *et al. Pre-existing mental health disorders affect pregnancy and neonatal outcomes: a retrospective cohort study*. BMC Pregnancy and Childbirth.2020, 20:419-422.
22. Micluția, IV, Popescu, CA, Macrea, RS. *Sexual dysfunctions of chronic schizophrenic female patients.* Sexual and Relationship Therapy. 2008, 23, 2: 119–129.
23. Micluția, IV, Damian, L, Șerban, AC. *Sexual Functioning in schizophrenic and bipolar female patients*. Proceedings of the European Conference of Psychiatry and Mental Health. Galați, Galatia, Filodiritto Editore. 2019, LaPsihiatru.ro: 16-21.
24. Anmella, G, Pacchiarotti, I, Cubała, WJ, *et al. Expert advice on the management of valproate in women with bipolar disorder at childbearing age*. European Neuropsychopharmacology. 2019, 29, 11:1199-1212.
25. Davies, P, Reubera, M, Grunewald, R *et al. The impact and challenges of the 2018 MHRA statement on the use of sodium valproate in women of childbearing age during the first year of implementation, in a UK epilepsy centre*. Seizure: European Journal of Epilepsy. 2020, 79:8–13.
26. Kurvitsa, K, Laiusa, O, Uusküla, M, *et al. Valproic acid prescription trends among females of childbearing age in Estonia: A 14-year nationwide prescription database study*. Seizure: European Journal of Epilepsy, 2020, 76:28–31.
27. Xu, F, Sullivan,E, Binns, C *et al. Mental disorders in new parents before and after birth: a population-based cohort study.* BJPsych Open.2016,2: 233–243.
28. Klemetti, R, Raitanen, J, Sihvo, S.*et al. Infertility, mental disorders and well-being – a nationwide survey.* Acta Obstetricia et Gynecologica. 2010, 89: 677–682.
29. Baldur-Felskov, B, Kjaer, SK, Albieri, V *et al. Psychiatric disorders in women with fertility problems: results from a large Danish register-based cohort study*. Human Reproduction. 2013,28,3:683–690.

30. Micluția, I. *Narcisism și sexualitate*, in Narcisismul între mit și realitate, ed. Aurel Nireștean, University Press, Tg. Mureș, 2021:55-62.
31. Ross, NE, Webster, TG, Tastenhoye, CA *et al. Reproductive Decision-Making Capacity in Women With Psychiatric Illness: A Systematic Review*. Journal of the Academy of Consultation-Liaison Psychiatry. 2021, in press.
32. Gromski, PS, Smith, ADAC, Lawlor, DA *et al. 2008 financial crisis versus 2020 economic fallout: how COVID-19 might influence fertility treatment and live births*. RBMO. 2021, 42, 6: 1086-1096.
33. Haham, LM, Youngster, M, Shani, AK *et al. Suspension of fertility treatment during the COVID-19 pandemic: views, emotional reactions and psychological distress among women undergoing fertility treatment*. RBMO. 2021,42,4: 849-858.
34. Getau, V. *Politici de creştere demografică: Cum a balansat natalitatea către femeile salariate și instruite. România și politicile familiale europene*. Curs de Guvernare, 2012.
35. OECD. Rejuvenating Korea: *Policies for a Changing Society*.2019 https://doi.org/10.1787/c5eed747-en 9789264637382 (PDF) : 196 p.