THE PROBLEM OF PREGNANCY TERMINATION ON PSYCHIATRIC GROUNDS

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MOST psychiatrists who are not irretrievably committed to extremist positions in judging the psychiatric grounds for termination of pregnancy, find the decision difficult and often harrowing. The extremes lie between those dogmatists, often the most vocal, who proclaim there is absolutely no justification for this procedure and the others who advocate abortion on demand. A comparable situation exists throughout Europe, where this country occupies an intermediate position between the permissiveness of eastern Europe (and Scandinavia to a lesser extent) and the harsher attitudes of southern Europe where Roman Catholic pressure is stronger.

Religious beliefs and moral prejudices are not the only influences to which psychiatrists are subjected, and these will be more fully described. Practical issues are highly pertinent. Agree to recommend termination and there is a risk of a deluge, with this particular problem displacing other clinical work. Refuse termination and referrals will cease from everyone except from those who seek exoneration by obtaining automatic rejection of the case. Most of us resolve this conflict by honestly judging each case on its merits. Unfortunately, there is a scarcity of adequate research data on which to base an objective judgment, and the literature in this country shows little agreement.

Yet the problem could be studied systematically to identify those patients for whom termination was superior to any other practical course of management. Mental hazards of pregnancy would have to be considered from all aspects, i.e. risk of suicide, puerperal psychosis, postpsychotic personality deterioration and resultant chronic neurotic disorders. The patients should be representative of the country as a whole because psychiatrists whose prejudices are known or suspect, will receive a selected sample. Adequate follow-up would be vital. It is notoriously difficult to trace patients whose appeal for termination has been rejected. Many refuse the psycho-

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logical support that is offered as the correct management, turning to the less reputable sections of the profession or to a medically unqualified abortionist. These will usually be resourceful people. It is a curious reflection on our present laws and social customs that it is personalities of this sort who are condemned to the illegal operation, when it may be that these importunate women are as liable to as much damage to their mental health as the obvious, psychiatric casualty who is readily granted therapeutic abortion.

The Scandinavian workers have come closest to clarifying these issues, being assisted by their radical legislation. In Sweden a special social-psychiatric committee meets regularly and consists of a psychiatrist, a gynaecologist and a woman with experience in social welfare and politics. Reports from the family doctor and a social worker are considered vital. The numbers studied are impressive. Ekblad (1955) examined the outcome in 479 women whose pregnancy was legally terminated and established that this was not a harmful procedure from the psychiatric point of view. The few exceptions were suffering from chronic and serious neurotic disorders, and they might have been worse if termination had been refused. In fact, Höök (1963) carried out a careful follow-up survey of 294 women whose application had been refused and discovered that pregnancy for many of them had been a harmful experience. Moreover, this sample comprised only 10 per cent of the applicants for abortion. In recent times this proportion has risen to 40 per cent as the committees have become stricter. It is unwise to draw general conclusions from findings in a foreign community. Again, however scrupulous the research, it is unlikely to serve as more than a guide to the psychiatrist. Confronted with the individual patient, clinical judgment based on medico-legal issues will be paramount.

The gynaecologist's position

The operative procedures are governed by the period of gestation. They carry a small risk in terms of mortality and morbidity, although precise figures are not readily available. Up to the tenth week, abortion can be performed most easily by curettage. After the twelfth week, hysterotomy may be necessary, but sometimes the uterus can be evacuated by introducing solutions per vaginam. From the twenty-eighth week the foetus becomes viable and its destruction therefore unacceptable.

Gynaecologists assume a central responsibility and are correctly jealous of their right to decide for themselves on the guidance available to them from a psychiatrist whose opinion they trust. A second psychiatric opinion is unnecessary, but may be desirable in the borderline case.

Interpretation of the present law

Exemption from committing a felony under The Offences against the Person Act, 1861 rests on case law, the precedent arising from *Rex v Bourne* in 1938. Mr Justice Macnaghten's judgment reads:

> If the doctor is of the opinion on reasonable grounds and on adequate knowledge, that the probable consequences of the continuation of pregnancy would indeed make the woman a physical wreck, or a mental wreck, then he operates in that honest belief, for the purpose of preserving the life of the mother.

The concept of ' mental wreck ' is picturesque rather than precise and through its very ambiguity it creates both its strength and its weakness, which many regard as a typical example of the maturity of the English legal system. Its strength is that ' wreck ' is sufficiently emotive a term to discourage any who might be tempted to co-operate in ridding a woman of the distress appropriate to a temporary embarrassment. Also, ' wreck ', being ill defined, can embrace any number of individual variations of psychiatric sequelae to pregnancy. Many regard this ambiguity as a weakness, offering such little guidance that they are restrained from recommending termination unless the wreck is total—presumably derelict and unfloatable. Most of us take the view that the law can be interpreted more widely and that although we terminate to prevent the development of a serious and prolonged psychiatric disorder, this might not necessarily be permanent, or incapacitating. The legal discussions in the Bourne case stressed the risks of later neurotic sequelae, resulting in mental instability, disturbed marriage and sexual fears.

Whatever our interpretation of ' wreck ', it should be necessary to make the diagnosis of a psychiatric illness and to recommend termination if it is the only effective or acceptable method of treatment of this illness. The illness might have antedated the pregnancy, but be exacerbated by it, or might be judged as likely to be intensified after birth.

A previous attack of puerperal psychosis does not generally justify termination, because although there is roughly a one in five risk of recurrence in a subsequent pregnancy, the condition responds well to treatment. However, exceptions do occur in women who become ill worrying about their future as a mother and wife, having seen their function deteriorate after previous pregnancies through mental illness. They may be convinced that the present pregnancy will result in similar illness and are unable to endure the suspense of waiting for their prognostications to be fulfilled. Termination may be the only means of averting their mental distress, and may be indicated in other unusual situations.

One of our patients had the following history:

> 1st pregnancy followed by puerperal psychosis of schizophrenic type.

2nd pregnancy. Termination considered but rejected. Puerperal psychosis number two.

3rd pregnancy terminated by therapeutic abortion. No postabortion psychosis.

4th pregnancy. Patient refused termination when offered. Another puerperal psychosis developed—number three.

She then consented to sterilization, but gradual personality deterioration ensued.

The threat of suicide is a common and harrowing problem. If the case for mental illness rests on this alone, termination should be unwarranted. A recent referral was a woman of 40, separated from her husband. She was a dynamic individual, holding a responsible public position, and supporting her two dependent children. Also, she was prominent in her small provincial community for her political and charitable activities. She enjoyed a long-standing, discreet relationship with a married man, by whom she was pregnant. Although upset, she gave a clear, undramatic account of how she would destroy herself, without arousing suspicion of suicide, by driving her motor-cycle over a cliff road, rather than expose herself and her children to disgrace. The termination issue aroused divided opinions and fortunately for everyone she had an (apparently) spontaneous abortion.

In such a case, strict adherence to a medical role leads to the position that if a sane, balanced person elects suicide if her appalling social dilemma cannot be relieved by termination, then this is a matter for legal reform. But many would be uneasy about relieving the doctor's conscience by shifting responsibility to the law, which is unlikely to be so modernized as to be totally permissive.

In practice, whatever the outcome of suicide declarations, fatal attempts are uncommon in pregnancy although there is, perhaps, a tendency to underestimate this risk. Incidence data are variable. In a country-wide survey in Sweden, Bergstrand and Otto (1962) found that two per cent of girls under 20, admitted to hospital with suicide attempts, had illegitimate pregnancies. Seager and Flood (1965), surveying cases of suicide recorded by coroners in the Bristol area over a five-year period, found that three of 136 females were pregnant. In two of these women the pregnancy was illegitimate, but in all of them it seemed to precipitate a stressful situation, directly related to the suicide. Definite evidence of psychiatric illness, as such, was difficult to assess as none of them had received medical attention and it is likely that where the risk of suicide is greatest, the women are those who are too socially withdrawn to seek termination. There is often a reluctance by some coroners to record a suicide verdict because of its social repercussions, and possibly there are half as many again where death by suicide is

reported as due to accident, misadventure or with open verdicts.

Scheme of management

Treatment and prevention of illness is the fundamental objective, and the methods proposed depend on careful assessment. Where doubt arises in the borderline case, it is often desirable and sometimes essential to admit the patient for observation. The practical difficulty is that the patient is often referred after two months amenorrhoea and time is short.

1. Where depression is predominantly reactive, the patient might be helped by manipulating the environment, arranging social help, or offering supportive psychotherapy. This may be rejected and other measures might prove inadequate, so that termination has to be strongly considered in such patients. One would be influenced by contributory factors to the depression which are unchangeable:

(i) *Eugenic.* The patient may be so morbidly preoccupied with the fear of a deformed foetus due for example to thalidomide, rubella infection or with fear of being a carrier of hereditary diseases, that termination proves the only means of preventing a prolonged mental illness.

(ii) *Size of family.* The social stress of large numbers of children in substandard conditions might contribute so powerfully to the depressive illness that the pregnancy can never be accepted, so that termination is the only treatment.

(iii) Other examples of intolerable social stress contributing to depression might be:

(*a*) A psychopathic, psychotic or unsympathetic husband.

(*b*) Absent male partner, i.e. by desertion.

Those who object to psychiatrists undertaking a non-medical role of the humanitarian in this issue say that termination is never justified on social grounds, and if these are exclusively socio-economic, most would agree. But usually these considerations interest the psychiatrist as much as the social reformer because of the inevitable influence of environment on mental health. This is explicitly recognized in Sweden where all applications must be accompanied by a full biography and social history from a case worker. The Swedish law recognizes sociomedical indications. Moreover, " abortion is also permissible when, in view of the woman's living conditions and other circumstances it can be assumed that the birth and care of the expected child will seriously undermine her mental or physical health ".

Thus Swedish law provides for abortion if it is probable that the woman's health will suffer from having to rear the expected child. Whereas in our law " the consequences of the continuation of the pregnancy " is generally interpreted as ending with illness caused by the actual birth of the child, and this includes the puerperal period.

2. Sometimes the depression is judged to be of the so-called ' endogenous ' type, either because of its severity, psychotic features,

or possibly onset of illness antedating pregnancy. Logically, treatment should be with ECT or antidepressant drugs, but here again the question of termination might arise, after considering the theoretical possibility of damaging the foetus by the anoxia of ECT under general anaesthetic, or the teratogenic action of drugs in the first trimester of pregnancy. One supposes that undesirable sequelae of termination, such as morbid self-reproach might be a severe risk in this group, but this depends on how effectively the depression has been treated.

3. *Neurosis.* The same remarks apply as with reactive depression. Severe anxiety or severe obsessional neurosis, uncontrolled by other measures, may sometimes justify termination of pregnancy.

4. *Psychopathy* and other disorders of personality are unlikely to constitute a reason for termination in itself, but may do so if complicated by one of the conditions already mentioned.

In psychiatric departments in general hospitals the bulk of the cases are not psychotic. At the London Hospital the overwhelming majority suffer from a reactive affective illness, sometimes associated with severe personality disorder. The prevalence of schizophrenia is under two per cent and this illness rarely warrants termination. In fact, the psychotic illnesses like schizophrenia and classical endogenous depression, respond well to physical treatments, so that patients with these conditions are unlikely to present much problem to the psychiatrist who rejects termination as the treatment of choice. Thus, these patients do not put the same pressure for termination on the psychiatrist as the non-psychotic patients, who present the main difficulty in management.

Subjective influences

In addition to religious and moral beliefs, there are other, less obvious influences, which operate often at an unconscious level in affecting the psychiatrist's judgment.

First, those factors which might incline us to view termination sympathetically:

(1) The patient is a girl under 17

(2) The patient has been raped or is pregnant against her will

(3) The patient is someone with whom the psychiatrist can easily identify—viz. a fellow practitioner would be the most striking example

(4) Where professional status is involved. An example might be a tendency to favour termination under pressure by colleagues. The acceptance of a fee for a private consultation creates difficulties, the bias operating in either way. Some psychiatrists, in fact, refuse payment in these circumstances.

Secondly, these following factors might be advanced as militating against termination:

(1) The patient is hysterical and demanding. She appears to exaggerate her

complaints.

(2) The patient threatens suicide or back-street abortion to exert pressure on the psychiatrist. She is manipulating and rejects any alternative to termination, which is interpreted as stubbornness born of personality rather than illness.

(3) The patient is unmarried. The social pressure is often so powerful that the psychiatrist is afraid of being influenced by her understandable anxiety. He may require evidence of more serious mental illness than could be allowed for a married woman.

(4) Religious, philosophical or legalistic scruples in the doctor sometimes projected to the patient, viz. a catholic woman pressing for termination might, it could be argued, come to reproach herself for the operation or blame the doctor.

(5) The history suggests that the demand for termination will recur as an annual event. Other issues arise (*a*) contraception is unsatisfactory, (*b*) sterilization may not be acceptable or frankly undesirable, as in a young woman with only two children. Such a woman, in say five years time, might find herself with a new husband and a desire for more children, not to mention the fact that her attitude to a pregnancy on that future date could be totally different.

To prevent further deterioration in mental health, sterilization may be more logical than termination (sometimes both are performed); the older the woman, the larger her family, the greater the indication for this procedure.

Abortion panels

In 1962, at The London Hospital, regular group meetings were convened to help those involved with the problems arising from this contentious subject. The members were the psychiatrists and social workers, obstetricians and their almoners. It was an important article of policy that the decision was not collective; rather it remained an individual responsibility of the psychiatrist who examined the patient and the obstetrician who would have to operate. This seemed in the patient's interest, as the other members, without a personal knowledge of the patient, would be at a disadvantage in one way, and yet be able to contribute because it is easy to be decisive when impartially confronted with a colleague's patient. Table I shows the total number of patients referred over the past three years with the numbers recommended for termination. Thus, over this period there has been a tendency for the number of patients referred gradually to increase, whereas the proportion terminated has not significantly changed.

Table II describes the recommendation rate for individual psychiatrists. A and B saw the majority of the patients referred, and their decisions are compared. Although the differences are not statistically significant the trend suggests they are changing in opposite directions. A, initially liberal and permissive, has developed more stringent criteria. For B, the reverse is occurring. Thus A and B are interacting in a dynamic way which is the result of group behaviour. In time their attitudes might be expected to equalize, so that individual prejudices of panel members should be corrected. When there exists a high correlation between the judgment of the

panel and that of each member, the latter might feel inclined to abandon their individual responsibility for the strength of collective decision. The support of the panel is of great value in dealing objectively with these harrowing problems, particularly in the borderline case where a unanimous decision is absent.

TABLE I

PROPORTION OF RECOMMENDATIONS OF PATIENTS REFERRED

Year	*Patients recommended*		*Not recommended*		*Total referred*
	No.	*Per cent*	*No.*	*Per cent*	
1962/63	12	*38*	20	*62*	32
1963/64	21	*48*	23	*52*	44
1964/65	24	*42*	33	*58*	57
Total	57	*43*	76	*57*	133

TABLE II

PERCENTAGE RECOMMENDATIONS OF THE INDIVIDUAL PSYCHIATRISTS

Year	*Percentage recommendations*		
	A	*B*	*C*
1962/63 ..	*50* N = 6	*27* N = 15	*40* N = 10
1963/64 ..	*43* N = 14	*45* N = 22	*66* N = 3
1964/65 ..	*41* N = 22	*60* N = 15	*23* N = 13
	N = Total number referrals		

There are other advantages of establishing abortion panels, possibly on the Swedish pattern. The gain to the profession would be to the public's advantage. The panel serves not only to reorientate those members who compose it, and here the family doctor would be a welcome addition, but also those in training who attend for instruction. Documented proceedings, with information from multiple sources, provides a firm basis for future research. If an impartial professional group were to be established, there should be no secret that its services are available to general practitioners in the district, and thereby to patients who consult them. This would improve the public image of the profession, conditioned by centuries of dogma that abortion is a crime. It is still widely believed that

abortion is an unrespectable, clandestine procedure, if not an illegal act, but that it is readily available to the wealthy and privileged. If doctors could meet the extra claim on their working time that would inevitably arise, they would be enhancing one of the proposed objects of legal reform which is to promote understanding between the medical profession and women mentally distressed by their pregnancy. Whatever the phraseology of new legislation, the ultimate interpretation will depend largely on the special facts of the case, and medical objectivity can be improved with panel discussion.

Summary

The general problems that arise in connection with therapeutic termination of pregnancy on psychiatric grounds have been reviewed. Interpretation of the present law is discussed. If new legislation redefines existing law, or extends it, this will not in itself serve as a panacea. No one can say whether it will diminish the number of illegal abortions, and certainly there is the likelihood of increasing responsibilities for the psychiatrist, gynaecologist and family doctor. Every case must be considered on its individual merit and the factors which influence medical judgment have been discussed. In parallel with legal reform there must be a change in the attitudes of both doctors and society. The establishment of abortion panels might contribute to this goal and the advantages that could result have been indicated in this article.

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REFERENCES

Berkstrand, C. G., and Otto, U. (1962). Suicidal Attempts. *Acta paediat. (Upsala)*, **51**, 17, 26.

Ekblad, M. (1955). *Acta Psychiat. scand.*, supp. 99.

Höök, K. (1963). *Acta Psychiat. scand.*, supp. 168.

Seager, C. P., and Flood, R. A. (1965). *Brit. J. Psychiat.*, **111**, 919.