Unwanted pregnancy in general practice

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SUMMARY. Evidence of identifiable character traits was found to exist in women requesting termination of pregnancy, and their relationship with their doctor was classified. To explain these phenomena a split in the personality is proposed. The two parts (the two selves) and the gap between are examined. A hypothesis for its production is considered.

Introduction

THE work is based on research done in a Balint seminar between 1969 and 1973 when 130 cases of women requesting termination of pregnancy were examined. These teaching and research seminars (Balint, 1964) were designed to make general practitioners sensitive to non-verbal communication and so permit them to be aware of the emotional content of a patient's communication. The emphasis was on patient-centred rather than illness-centred medicine. Sometimes a consultation made sense only when considered in these terms. Examination of the doctor/patient relationship was the focus of the discussions. The effect which the patient and doctor had on each other and the reasons why they acted in the way that they did toward each other had to have a meaning in terms of their underlying personalities.

During this period ideas developed about how these women came into this situation and how this linked with the types of doctor/patient relationships discovered in the seminar. It was felt that the clinical events could be explained if there was a split in their personality of such proportion that there was, at least at the time of the conception, no communication between the two parts. In an approximate way the parts could be said to be the baby-wanting one (personal self) and the more practical one (worldly self).

Two articles about this research have already been published (Tunnadine, 1972 and 1976) and a further comprehensive review is in press (Tunnadine and Green, 1978).

Aim

A preliminary study was designed to see the extent of the problem and examine the doctor/patient relationship. The general study continued along these lines but in addition set out to determine the characteristics which many of the women had in common.

Method

The seminar was conducted at University College Hospital, London, under the leadership of Dr Michael Balint until his death in 1970. It consisted of general practitioners in active practice presenting their own cases. There were other medical and lay workers who could take part in the discussions but they did not have day-to-day responsibility for their patients as did the general practitioners.

The two-hourly weekly sessions were tape-recorded and the resulting 4,000 pages were later read and analysed. The research material discussed in this article was made up of two parts: a preliminary and a general study. Patients in the preliminary part (47) included all those within a defined period where there was any, or even a suggestion of any, interruption of a pregnancy. Those in the general part (83) were defined in the same way but they were randomly selected by the general practitioners.

In this paper it is proposed to describe two patients, Miss A. and Miss B. It is not suggested that two cases are enough to cover every aspect of women requesting therapeutic abortion. It is difficult to allow for every variable such as age, marital state, and social and cultural background. These two cases do, however, embody many of the features found in this group of women and are useful in showing how the conclusions were reached. Because the atmosphere of the consultation is important

and the general practitioner was attempting to be non-directive, the cases are set out in more detail than might otherwise have been thought to be necessary.

Results

Patient 1

Miss A., aged 15, was the daughter of a patient whom her general practitioner had had to have admitted to hospital with a nervous breakdown. Miss A. had seen every partner in the practice. While her mother was away she had had sexual intercourse. Afterwards she was worried and told her mother, who came immediately on her discharge from hospital to see her doctor. Apart from their exchange about what had happened, daughter and mother had not talked about it together. The doctor gave them another appointment which they did not keep. Then Miss A. began playing truant from school. It took about a year for her to be discovered. Her mother was very angry. She thought the only solution was to send her to a centre where she could be "sorted out". It was arranged that she should be away for about six months. As might be expected, Miss A. did not like the discipline and discharged herself within a couple of weeks. A few days later she went to a party, had sexual intercourse with a young man and became pregnant. The father of the pregnancy soon faded from the scene.

Miss A. and her mother were seen separately and each wanted the pregnancy to be retained. The sole reason that the word abortion was mentioned was that they both feared that those in charge while she had been away might require her to have one, as they had been nominally responsible for her at the time. Miss A. showed little emotion, apart from complaining of a lump in the throat.

The reasons given by both for having the baby appeared childish. The daughter thought that it would show everybody what a bad mother she had. The mother, for her part, wanted to retain her influence over her daughter. She thought that the daughter was becoming too independent and she would be able to regain control through the child.

After the birth the three stayed together, at least for a while. But as time went by the daughter did not find that she had had any effect on the mother. Miss A. became fed up with the situation at home and left and went to live with a man with two young children. It was not long before she returned to the doctor pregnant once more.

It might appear that the first pregnancy was initiated in order to break with mother but why, when it succeeded at least partially, did she need to become pregnant again? Unless she was very unrealistic, she could have hardly thought that the second child could make her more free. Indeed, there was something in this girl which required her to become pregnant, which was not the same as being pregnant, and certainly not the same as having a baby.

She has many of the traits seen in the various research cases which are described below. Some of them will also be observed in Patient 2.

Characteristics of patients requesting abortion

1. Difficulty in maintaining a continuing doctor/patient relationship, shown by (1) the tendency for failure of a follow-up consultation, no matter how keen the doctor was; (2) the frequency with which the patient wandered within a practice or even disappeared.

2. The patients have an unsatisfactory relationship with their mothers, either close, clinging, oppressive, or distant, but at the same time important and often distinctly disturbed, and sometimes a mixture of both.

3. The patients often showed surprisingly little feeling in what one might have expected to be a highly emotional situation, and even sensitive and understanding doctors were unable to get a close rapport with them.

4. The doctors felt that the patients were trying to control the relationship: they were secretive about themselves and their situations, and they tended to be manipulative.

5. In those cases in which the doctor did not feel manipulated or controlled he was often overwhelmed by masses of irrelevant information coming from all sides—relations, social workers, teachers, priests, and boyfriends—ending up with a view of a crazy world or a crazy patient.

6. Little, if any, information was given about the patient's sexual life and that which was given indicated most unsatisfactory situations. The idea that they were leading fulfilled and happy sexual liaisons which had led on to an unwanted pregnancy was rarely confirmed; indeed they were often disorganized and inadequate in their sexual adventures.

7. The father of the pregnancy was usually irrelevant and often absent.

8. The timing of the conception of the 'unwanted' pregnancy often happened soon after a major change or crisis in the patient's life—leaving home, a broken engagement or relationship, a threatened marriage, children going to school for the first time or away to boarding school, teenagers leaving home, death of parents or grandparents, the threat of the menopause leading to loss of womanhood—in summary, a break in a relationship, whether real or imagined.

9. When any information could be gained about the patients' contraceptive arrangements, they were either woefully absent, even in apparently intelligent and knowledgeable people, or they had recently been changed from a tried, efficient method to one with a much higher failure rate or to one under the woman's own control when there would be some unaccountable

lapse, uncharacteristic of their usual highly regulated existence.

10. Sometimes there was a second unwanted conception, as if this kind of accident was almost a character trait of a particular type of personality. Sometimes a further termination was sought.

11. A further feature was the apparent irrelevance of the baby to come, and even when kept, its lack of real meaning to the patient.

Patient 2

Miss B., came with a rather ineffectual man who was much older than herself. He had never married and was closely involved with his parents. She was seven weeks pregnant. Miss B., her boyfriend, and the doctor agreed that she should have an abortion. It would be done privately and the man would pay for it. There was no discussion.

The doctor had seen her nearly a year before, when she was 22 weeks pregnant. After the confinement the baby had been adopted. He had discovered that she had become pregnant while having a liaison with a married man who was estranged from his wife. He had wanted her to have the baby but when she was eight months pregnant he had deserted her.

At the time of the presentation of the case in the seminar, the abortion had already taken place. The group felt that they knew some of the facts but had no idea why Miss B. had become pregnant twice, in most unsuitable circumstances, each time to a much older man, with only a remote chance of the baby having a father to support it. The general practitioner was urged by his colleagues to spend more time with her and see what he could discover. He therefore asked her to make an appointment at the end of his surgery. She came and spent an hour and a half in conversation in his consulting room. Every time that he thought the interview was coming to a close, she would light a cigarette and start talking again.

She had been drinking heavily since the abortion. She went into a long story that her boyfriend and herself had been involved in a car accident, and at another time that he was concerned in a fight with another driver after another incident. She was now frightened of being with him when he was driving, in case she was hurt. She also seemed unduly worried that her parents might become ill, although there was no reason for her concern.

A furore appeared to be going on around her and she seemed to be particularly anxious about trouble for, and damage to, those most close to her. The doctor did not, or was not allowed to, take up these matters with her, even though the atmosphere of the consultation was friendly. Miss B. did not wish to discuss the abortion. The general practitioner did not really understand what was happening and asked her to come for another long interview on the next Saturday morning. However, when the day came, she had overslept. She apologised but did not make another appointment.

In summary, it was clear that she had come to the long interview for something other than to discuss the abortion. She soon realized, or at least her doctor did not show her otherwise, that he did not understand her illness or herself, or what her problems were. She responded by not returning.

This patient is quite different from Miss A. She is much more in charge of her own affairs. Miss A. was seen to be acting out something with her mother and what happened between herself and the doctor was bizarre and irrelevant. She had no effect on the doctor and he certainly had none on her. Such a relationship the seminar called "crazy". Miss B. was much more in control. She manipulated the doctor to do what she wished. These were two quite different relationships and there were others as well.

The doctor/patient relationship

As stated above, one aim of the seminar was directed to analysing the doctor/patient relationship and it was found possible to classify it under the following headings: crazy, football, confusing, featureless, controlling, and matter-of-fact. They are defined as follows:

1. Crazy

In this group the woman appears bizarre and non-communicative. She is given to missing appointments. There is confusion and misunderstanding which lead to a crazy relationship. Thus the patient does not seem overconcerned by the predicament of the pregnancy, just rather frightened and anxious. She is too busy with her problems to make a relationship with her doctor. Such a person was Miss A.

2. Football

There were a group of women, usually young, who seemed to have no willpower at all. They were kicked, figuratively speaking, from pillar to post, either by husband, boyfriend, parents, or doctor. They forced someone from their environment, especially their doctor, to decide for them. However hard the doctor tried, he could not find out what they really wanted; they threw themselves on his goodwill and he was forced to take all the responsibility, although he was not allowed to find out what had really happened or what had created the painful situation in which they required his help.

3. Confusing

This relationship is not so striking as the 'crazy'. The patient appears to know where she is going and what she is doing, but is given to sudden changes of course. It is almost as though there are two parts of her which have to be satisfied: the first lives in this world and requires the abortion and the second wishes to continue with the

pregnancy. This leads to an in-and-out relationship with her doctor. He finds it very difficult to understand her. She changes not only her decisions from moment to moment but also her rapport with the doctor. She is at one time cold and manipulative and the next warm and submissive.

4. Featureless

To try to describe this type is, by definition, asking the impossible. How can one describe a featureless relationship, except by an unending list of the features it lacks? The absence of coherence is not due to the doctor but is inherent in the patient. For her own reasons she is not very sure of herself, and does not want to be questioned or challenged. She withdraws from any unnecessary contact with people such as strangers and those holding power or authority, and the doctor would obviously be included in this group.

5. Controlling

In a controlling relationship the doctor feels hemmed in and controlled by the patient's mode of presentation, the time factors, her relatives, spouse, other doctors and any other allies or facts which the patient can call upon in order to manipulate the doctor towards the decision she wants from him—a therapeutic abortion. Any attempt made by the doctor to temporize, or make time in an effort to get at the truth, or gather enough of the facts to make a balanced decision is met by further resistance, facts, moves, or manipulations until the doctor gives in and makes the 'right' decision, according to her.

6. Matter-of-fact

Matter-of-fact relationships are easy and straightforward. The position is made clear by the patient, all the relevant facts are given, and the rational answer is obvious—a therapeutic abortion. The doctor feels a little uncomfortable, as if he has never really got to grips with anything, or even needed to; it was all so matter of fact. It will of course be so only when the patient's approach to the pregnancy and its solution agree with the doctor's.

Discussion

The patients' personality

How can we understand such patients? On the whole, it could be said that they were lonely and slightly withdrawn. Their main aim as far as the doctor was concerned was to place a defence against being understood. Could this be because of their fears and anxieties, or was there something special about these women— more than their being just at one end of a spectrum of women whose situation and lack of support caused them to require an abortion?

Many writers over the last few years have proposed a split in the personality (Winnicott, 1965; Guntrip, 1968; Laing, 1970). Although theoretical in origin it has its uses in explaining some human behaviour.

In women requesting a therapeutic abortion the two parts can be said to be the one wishing for an abortion and the other for a pregnancy. These are the two selves described below.

The personal and worldly selves

A person can be said to contain two selves, a primitive, personal self and a civilized, worldly self. They are separated by an unbridgeable gap. The split is really a matter of non-communication between the halves of the individual.

The personal self has strong feelings of love and fear and strong needs to be in an accepting, understanding, that is, a loving relationship, with at least one person at this deep primitive personal level. It is not reasonable or logical, and probably not even capable of formulating the above needs and feelings verbally.

The language of the personal self is dreams, art, and the unconscious. In a split individual the personal self will tend to fear and dread the impingement of the outer world of reality and other persons, but will feel weak and helpless and in danger of dissolution if without a relationship, and will fear the primitive strength and ruthlessness of its own feelings of love. These contradictory forces will lead to an in-and-out relationship with another person as well as the pregnancy.

The worldly self is built on a compliance basis, as an outward image with which to relate to outer reality. It is made up of the many roles which the person fulfills—at work, as a parent, spouse, child, neighbour, friend—trying to live up to the image which he has of himself and to a degree the images others have of him, in so far as he needs their esteem, love, and approbation.

In the split individual these roles and images can be in conflict and the ways of achieving them stereotyped, not being open to adaption to reality, or the needs or feelings of another person; for the worldly self, although rational and logical, has no true deep feelings, so that it has great difficulty in assessing them in others and modifying its behaviour in accordance with them. The worldly self may have well-marked aims and intentions, which may or may not be the best ones for that whole person, the personal and worldly selves, which will in the final analysis depend on what degree of contact and understanding there is between these selves in spite of the split. Also the methods employed to achieve the aims and intentions may well be misjudged, in that the worldly self can be a poor judge of others, their feelings and needs, and even intentions and motives.

The function of the worldly self is to protect the personal self from the dangers of impingement and destruction by a hostile world and to modify the overpowering strong feelings and needs of the personal self, to the reality of the world. It is the communicator, the strainer of information, the custodian between the outside world and the personal self. Unfortunately, the job of protection can all too easily turn into protective

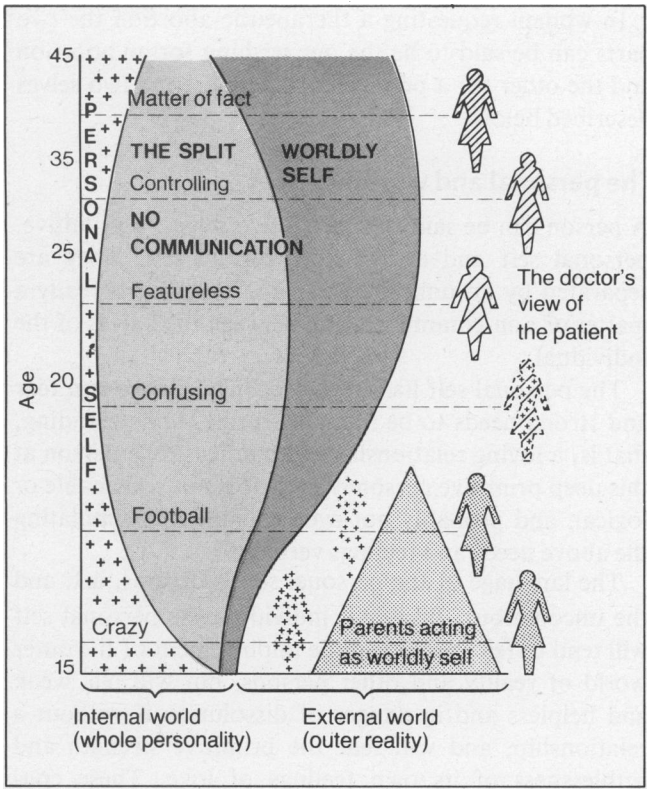

Figure 1. *The split and the two selves. (Source: Tunnadine, D. & Green, R. (1978). Unwanted pregnancy—accident or illness? Oxford Medical Publications).*

custody, and the guardian then becomes the jailer.

How do these theoretical constructions of intrapsychic mechanism appear in the material collected by the seminar? The worldly self is all too apparent in that it is this side of the patient which presents to the doctor with all her facts and reasons, with surprisingly little feeling and emotion. It is the part which attempts to control the consultation and its outcome, although in rather unsubtle and inappropriate ways. The personal self is by no means so obvious, for it is hidden amongst the woman's many secrets by the worldly self's machinations. It can be elicited by a doctor prepared to understand non-verbal communication, dreams, and the unconscious reasons behind apparent craziness. This split is demonstrated by the case of Miss B.

Following the interview already reported, Miss B. continued to see her general practitioner from time to time, but kept him at a distance. About 18 months after the abortion, however, she had had a deep vein thrombosis. She was admitted to hospital where she was given the appropriate treatment, including anticoagulants. Afterwards she began to attend the surgery more and more frequently with panic attacks.

On one occasion she reported that she had had a dream. She said she had seen the blood in her vein clotting, which then went around her body. Subsequently she had become very anxious about her brain and her heart. On waking she felt very worried and was soon involved in a quarrel with her boyfriend. They had a blazing row, but had made it up the next night, and she had been very comforted by being in his arms.

Dreams can be very illuminating in gaining a view of the personal self. In the dream it could not have been more clearly said that there was a conflict between her feelings and her intellect, between her heart and her brain. For a moment the personal self and worldly selves are brought together. The stimulus of the illness had brought flooding to the surface dreams and feelings—the symptoms of the personal self. When Miss B. is confronted by these unfettered emotions of love, fear, anger, and tears, she becomes frightened. The worldly self is concerned that *they* will cause her to lose control. The dream is rapidly followed by an outburst of anger, but she is much comforted by feeling the secure embrace of her lover.

This dream highlights the existence of the two selves. The lack of communication between them is the basis of the 'illness' (in the Balint sense). This gap can be of any dimension. As the distance widens it becomes less and less likely that the worldly self will take cognizance of the personal. The latter is there but hidden. Also the stronger the wordly self, the more difficult it becomes to view the personal. The personal self has no strength. Its effect on the whole person will be entirely dependent on how well formed the worldly self is and the space between the two selves. How does this concept fit in with the doctor/patient relationship as seen in the research?

Doctor/patient relationship and the two selves

It can be seen from the classification of the doctor/patient relationship that a two-way gradation runs through the whole group (Figure 1).

First, the worldly self is so poorly developed as hardly to exist in the group called 'crazy'; and as one progresses through the groups the worldly self becomes more and more developed, until in the 'matter-of-fact' it presents a very acceptable and 'normal'image to the world.

This gradation looks superficially like a healthy maturing process, but is really a more successful attempt at building up a false self on the basis of conforming to the rules and fashions of the outside world, rather than a healthy development of a mature whole person.

The second gradation is that less and less of the personal self is observable as the cases again run from 'crazy', where all too much of the chaos of the internal world and the irrational feeling self is apparent, to the 'matter-of-fact' where no glimpse of feeling is apparent because the well organized worldly self blots it out. With these two gradations runs a third, that of the emotional age of the patient, the young early adolescent as 'crazy', the late adolescent as a 'football', the young woman as 'confusing' and then becoming 'featureless', 'controlling' and 'matter-of-fact' as she gets older; if

not in years at least in experience.

The only constant running through all the cases is the split or lack of communication between the two selves which will give rise to a consistent difficulty in making healthy understanding relationships with another person. Such an explanation would account for the types of doctor/patient relationship observed.

The little womanikins (cf. manikins) represent the view the doctor, and outer reality in general, obtains of the patient. The density and thickness of outline is meant to represent the amount of worldly (firm) and personal self (faint) which is perceivable—the definition of the person as a coherent character and the rigidity or adaptability of this character. Ideally a person would have a uniform healthy shading with a clear outline, but not rigid.

It is interesting to speculate why many of the women requesting termination of pregnancy seem to have this split.

If the degree of maturity as exemplified by Winnicott's (1965) scale of dependence/independence is considered (extreme dependence, dependence, dependence/independence, independence/dependence and independence), it is seen that the patients had most constant difficulty when they had to relate to another person at the stage of the dependence/independence mixture.

The most constant person with whom they had problems was their mother which would lead to a pathological dependence of the daughter on the mother. The basic fault probably occurs at the time of separation (weaning) from her mother. At that time the daughter has to learn to disguise and defend her defect by the formation of a false self, that is, the wordly self, which will cover up the personal self's feeling of inadequacy, weakness, and need for love.

This type of immaturity manifests itself when the craving for love and mothering is mobilized by some real or apparent loss, such as the withdrawal of an important love object in the girl's world. She is searching for someone to mother her. This is more obvious in the young patient. Unfortunately the only method she has available in recreating the mother/daughter relationship is for her to be the mother—but how can a child care for a mother? Of course in this context it is only the subconscious fantasy world which is being discussed. When the reality of a pregnancy occurs, an abortion then is requested.

Conclusion

Just over 100,000 abortions were performed annually in England and Wales (DHSS, 1977) from 1972 to 1976. It is to try to understand this phenomenon that this research is devoted. The hypothesis would appear to correspond to the facts as seen in the research material. It will be for those workers who meet this problem in practice to verify for themselves the truth of the conclusions.

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The professional attitude

This old established philosophy of image related to role in society has recently come under fire in the United States of America. In the University of Missouri, Kansas City Medical School has dismissed a female undergraduate prior to her taking her final examinations. The young lady in question had had an outstanding academic record before entering university and had maintained high marks throughout her college course in medicine. Academically no fault could be found with this student but she was considered unsuitable to be allowed to graduate as a doctor of medicine. It was alleged that her tardiness, bad grooming, and abrasive personal style rendered her unfit to be a practising physician. It seems that teachers in the medical faculty had tried repeatedly to impress upon the girl that personal appearance, good grooming, and personal relations with people are essential if the confidence and respect of the patient is to be gained. Despite their efforts the student remained refractory and upon dismissal took the university to a court of law.

The outcome of this case will be awaited with some concern by the health professions in America. If the court upholds the student's case then, in effect, it will have ruled that no academic institution, in particular a school of medicine, shall have the power to enforce those standards of behaviour and appearance deemed necessary for the profession.

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