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Psychiatric Experience of the Abortion Act (1967)

By N. A. TODD

Introduction

Public controversy surrounds the workings of the Abortion Act and will no doubt continue to do so, probably until such time as surgical operation is replaced by other methods. Recently the report has been published of the enquiry by the Royal College of Obstetricians and Gynaecologists which emphasises the difficulties involved in interpretation of the Act and the variations encountered in practice. There is a substantial body of psychiatric literature on the subject, e.g., Ekblad, 1955; Arkle, 1957; Kummer, 1963; Sim, 1963; Höök, 1963; Baird, 1967; Clark *et al.*, 1968 and Kenyon, 1969, but results obtained in other countries and in this country some years ago are not necessarily applicable to this country now, since changes in public attitudes are likely to influence them. Little has been published by psychiatrists about their experience with cases since the Act came into operation. The recent follow-up series of Pare and Raven deals with cases seen in the years 1962 to 1968, i.e., mainly before the implementation of the Act.

It is possible, and indeed usual, for the problem to be regarded as a psychiatric one, but in many cases the considerations influencing decision could more appropriately be considered as social or humanitarian. I exclude, of course, the small number of cases in which physical illness is involved. Whatever one may think of this, the numbers referred to psychiatrists appear to be increasing, at least in the area of this survey.

Any generalizations applied to other areas must be very guarded in view of the great variation in practice from one region to another.

As an example of this, the Scottish Home and Health Department gives the figures for the first eight months of the Act, the figures being expressed as abortions per 1,000 births.

The Scottish Western Region, where the present survey was carried out, has by far the lowest rate (17·2) for any Scottish region, and less than half of the average rate for England and Wales (38·7).

The present survey deals with all cases referred for opinion as to the advisability of termination of pregnancy and seen by senior psychiatric staff of Leverndale Hospital and the Victoria Infirmary, Glasgow, during the first two years after the Act came into effect, i.e., from 27 April, 1968 to 26 April, 1970. Cases were seen in rotation by eight psychiatrists, only four of whom, however, were present for the whole two years. As a rule, the referrals were made specifically for opinion on termination, and there was little expectation on the part either of patients or of referring doctors for other means of treatment or continuing care. Follow-up or social work help were arranged when they were thought to be indicated, but most cases reverted to the care of the general practitioner once the decision on termination had been taken.

The patients were referred by their general practitioners or by gynaecological staff of the Victoria Infirmary and Samaritan Hospital. They came from the areas normally served by these hospitals and by Leverndale Hospital, with two exceptions who came from Canada. These were recent emigrants who were returning to their home area because of problems raised by pregnancy. The majority actually came from the Leverndale catchment area, consisting of Glasgow south of the River Clyde. The area served by the gynaecologists, however, is a wider one, so that some of the patients came from parts of West Scotland outwith Glasgow.

Results

During the two years, 116 patients were seen and termination was recommended in 83

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TABLE I

April—December, 1968

Annual abortion rate per 1,000 live births

North	North-east	East	South-east	West	Scotland	England and Wales
46·6	40·6	33·2	28·8	17·2	23·8	38·7

(71·5 per cent). Seven other patients had appointments made but failed to attend. The numbers referred more than doubled in the second year, 38 being seen in the first twelve months (73 per cent recommended for termination), and 78 in the second (70·5 per cent recommended). Ten patients were seen by two of the psychiatrists, the remainder by one only. When termination was advised, the general practitioner concerned often agreed to make the second recommendation. In other cases the gynaecologist did so, e.g., if the general practitioner had objections on grounds of conscience, if there were no regular family doctor, or if the gynaecologist had initiated the referral. In two cases recommendations for termination were not carried out by the gynaecologist.

Sterilization in addition to therapeutic abortion was recommended in 22 cases, but it is not yet known how often this was carried out.

DIAGNOSIS

It will be realized that the diagnostic label alone conveys little of the essence of each individual case, in whose assessment both external stresses and inherent vulnerability have to be taken into account.

It is noteworthy that only one case of major psychosis appears in the series. This was a manic-depressive patient, already well known in the hospital, whose breakdowns had usually but not always occurred in the puerperal period; social factors played an important though secondary part. In the patient with epilepsy, this condition was of only minor significance, the main problem being depression related to an adverse and intractable marital situation.

The great majority of the patients fell into the categories of reactive depression, anxiety state, personality disorder and 'no psychiatric abnormality.' In the patients with depression or anxiety, the symptoms were clearly a reaction to the unwanted pregnancy.

TABLE II

Diagnosis

	No. seen	Termination recommended
Manic depressive psychosis	1	1
Mental deficiency ..	2	2
Alcoholism	1	1
Epilepsy	1	1
Reactive depression ..	76	67 (87%)
Anxiety state	14	7 (50%)
Personality disorder ..	8	4 (50%)
No psychiatric abnormality ..	13	0
Total	116	83 (71·5%)

PSYCHIATRIC HISTORY

Only 13 per cent of cases had a history of previous psychiatric illness, and less than half of these had been referred to a psychiatrist. Two of the former in-patients were not recommended for abortion. In one, seen in the fifth month of pregnancy, termination was thought unlikely to influence the personality disorder present: the other was a moderately neurotic

TABLE III

History of previous psychiatric illness

	No.	Termination recommended
In-patient	6	4
Out-patient only ..	1	1
Treatment from G.P...	6	5
No treatment	2	2
No psychiatric history	101	71

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woman with obsessional features for whom it was thought that termination would be likely to have adverse effects.

In addition, six patients had a family history of psychiatric disorder, and in all of these termination was recommended.

Suicidal Risk

This was given a wide interpretation to include not only the patient's threats and past suicidal attempts, if any, but also a family history of suicide or personality features which led the psychiatrist to mention the possibility of suicide in his report, even if it had not been directly threatened. Some risk was judged to exist in 40 cases, of whom 36 were recommended for abortion. In the other four the risk was considered either to have passed or to be negligible.

Social/Demographic Factors

1. *Marital status* (Table IV)

More married patients than single were seen, and termination was recommended more often in the married than the single, the difference being significant at the 0·05 level. Marital adjustment was also rated roughly as good, fair or poor, and there was a tendency to recommend abortion more often when the quality of the marriage was considered poor, but the figures do not reach statistical significance.

Table IV

Marital status

	No.	Termination recommended
Married (47%) ..	55	44 (80%)
Single (39%)	45	28 (62%)
Cohabiting	2	2
Separated	9	7
Divorced	5	2

2. *Age* (Table V)

Termination was recommended more often with increasing age of the patient. The difference in rate between the under 20s and the 20–30 age group is significant at the 0·05 level. All but one of the girls under 20 were single. The youngest were three girls of 16, of whom one was recommended for abortion.

Table V

Age

	No.	Termination recommended
Under 20 years ..	23	9 (39%)
20–30 years	50	36 (72%)
Over 30 years	43	38 (88%)

3. *Parity* (Table VI)

Termination was recommended more often in those with than in those without existing children, but the difference just fails to reach significance. The group with one child showed a high degree of stress in their environment, all but one of the 16 being single, divorced, separated or having unusually severe marital difficulties. Of those with no children, all were single but two, and these were extremely neurotic women, both aged 39, who seemed and considered themselves to be unfit for motherhood.

Table VI

Parity

Children	No. of patients	Termination recommended
4 and over	22	18 (81·8%)
3	17	14 (82%)
2	22	17 (77%)
1	16	12 (75%)
0	38	21 (55%)
Not stated	1	1

4. *Religion* (Table VII)

This was not stated in 17 cases, and all that one can comment is that the major religious groups are represented. As a background to this, it may be of interest to note that the Roman Catholic proportion of the population of the City of Glasgow is given as 30 per cent compared with 17 per cent for Scotland as a whole and 8 per cent for England and Wales.

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Table VII
Religion

	No. of patients	Termination recommended
Protestant	67	45 (67%)
Roman Catholic ..	28	23 (82%)
Jewish	2	1
Muslim	2	2
Not stated	17	12 (70%)

5. *Social class*

There was insufficient information to determine this accurately but only 13 patients were judged to belong to social groups I and II, or to have continued schooling beyond the normal leaving age, and termination was recommended in 63 per cent of those.

Cases of Over Three Months' Gestation

These were considered separately since they are a particularly worrying group. Care was taken that no significant delay, i.e. not more than one week, should be caused by waiting for appointments. There were 23 patients beyond the third month of pregnancy, and termination was recommended in 10 (43 per cent). There is a natural reluctance to recommend interference when the foetus may be approaching viability, and when the increased risk of an abdominal hysterotomy is involved. This reluctance may be reflected in the lower rate of recommendations made.

On the other hand, some of these patients are particularly disturbed. The group as a whole tended to be younger than the other patients in the series and to be more often unmarried, but the numbers are not significant. Only two claimed to have taken reasonable contraceptive precautions. Some of these girls delayed consultation for fear of their parents' disapproval. In others, denial was a prominent mechanism. They would not believe they were pregnant, in spite of the evidence, or they persisted in the belief that some erratic and absent boy friend would return. Such denial is likely to have made subsequent acceptance of the pregnancy more difficult.

The two cases in which the recommendation for termination was not carried out come into this stage of later pregnancy. Six of the eight in whom termination was actually carried out were considered to be suicidal risks.

Contraception

This information was recorded in 75 cases. Only 19 claimed to have used the more reliable contraceptive methods (pill, I.U.D., cap or sheath). Fourteen had used unreliable methods (safe period or withdrawal) and 42 admitted taking no precautions. Amongst the remainder it is unlikely that contraception was extensively practised, since where there had been a definite contraceptive failure this was usually stressed by the patient and consequently recorded. The question of future family planning was usually discussed, but as a rule the arrangements would actually be carried out by the family doctor or gynaecologist.

Follow-up of Cases Not Recommended for Termination

Follow-up was carried out by a postal questionnaire sent to the general practitioner or other referring doctor and supplemented in some instances by telephone calls. Information was requested on the outcome of the pregnancy in the terms detailed in Table VIII, together with a rough estimate of the patient's mental state. A complete response was obtained.

There were 33 patients, of whom 17 were single, 11 married, 2 separated and 2 divorced. One third of these patients obtained abortion elsewhere, six of them under the N.H.S. and four privately, while another patient refused to divulge the circumstances of the operation. In yet another case (tabulated as 'unknown') the general practitioner suspected

Table VIII
Cases refused termination

Termination performed elsewhere	11
Presumed spontaneous abortion	1
Stillbirth	1
Child kept	15
Child adopted	4
Unknown	1
Total	33

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that abortion had been carried out but could not confirm it.

Four of those who had abortions elsewhere were married; the rest were single. The proportion of cases obtaining abortion elsewhere is similar to that in Pare and Raven's series, although abortion had been recommended less often in their cases (52 per cent) compared with the present series (71·5 per cent).

Fifteen patients continued the pregnancy and kept the child, this being 45·5 per cent of the group refused termination and 12·9 per cent of the original 116 referred. Eight of them were married, three single, two separated and two divorced, but the two divorcees and one of the single girls married the putative fathers.

In four cases, all single, adoption or fostering with a view to adoption was arranged. Actually five infants were involved since one patient gave birth to twins.

Information about the patient's mental state was given in 24 cases. If there was no comment on this point this was taken to mean that the patient had not recently been in contact with the practitioner. Twenty-two patients were reported to have made a good adjustment to their situation, and these included the two with a history of in-patient psychiatric treatment. The less satisfactory results were in a single girl, described as 'tense and quiet', and in a feckless married woman with a disorganized family life who had nevertheless not shown any deterioration resulting from the pregnancy. No suicidal attempts were reported.

The two patients for whom abortion had been recommended but not carried out should also be mentioned here. One was thought to have made a satisfactory adjustment: the other was coping adequately but under strain.

No systematic follow-up has yet been made of the patients in whom termination was carried out. It may be relevant here, however, to consider the results of Pare and Raven, who found remarkably little psychiatric disturbance following abortion, provided the patient herself wanted the operation. In the present series the only patient who showed a significant degree of ambivalence and who was recommended for abortion was the manic-depressive case, and the result was considered satisfactory.

Discussion

The major psychoses and mental deficiency formed only a small proportion of cases referred for opinion on termination, and this continues a trend which has been apparent for several years before the Abortion Act, as is shown by various papers, e.g., Kenyon, and is probably the experience of most psychiatrists. Only 6 per cent of cases in the present series had had previous contact with psychiatrists, all the rest having been referred for the first time because of their reaction to unwanted pregnancy, although a similar proportion reported psychiatric disturbance either treated by their general practitioner or untreated. It could be claimed, however, that those who were recommended for abortion might otherwise have become the chronic psychiatric cases of the future. Indeed, if one could make such a prediction with high reliability many of the difficulties would be resolved. With the major psychoses and mental deficiency one is on firmer ground, but it is difficult to draw a hard and fast line between neurotic disturbance and what might be considered normal degrees of distress and unhappiness, which are presumably also aspects of 'mental health', the term employed in the Act.

In many such cases the general practitioner, with his previous knowledge of the patient and her background, may be in a better position to advise than the psychiatrist who sees her for the first time at the moment of crisis.

While abortion remains a surgical procedure, with definite physical risks, the ultimate responsibility lies with the gynaecologist, and he must have the last word. The opinion of local gynaecologists will largely determine the way in which the Act is implemented in each area. The report of their College shows that these attitudes vary considerably, but almost all reject unlimited abortion on demand. In this series, differences of opinion between gynaecologists and psychiatrists very seldom gave rise to problems. The attitude of theatre or nursing staffs is also very important, and instances of refusal to co-operate and of resignation have been reported.

The Act does not allow for abortion on

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demand, but demand is a fact that cannot be ignored. The changing climate of both public and medical opinion in recent years is no doubt responsible for this. Not only is the number of requests for abortion increasing, but it may be that women are less able or willing to adapt to, or even tolerate, the burden of unwanted pregnancy than they were in the past. The eleven patients (at least) who did not accept refusal and obtained abortions elsewhere seem to illustrate this point.

Prevention of unwanted conception would of course be the ideal solution, even if unlikely ever to be completely attained. The low incidence of adequate attempts at contraception in the series is noteworthy, and it is greatly to be hoped that improvement in family planning can be achieved.

The Government inquiry into the workings of the Act, now in progress, will give an opportunity to take stock of the situation. It has been stated that there will be no attempt to alter the general principles underlying the Act. In the present series the concept of 'mental health' was given a fairly wide interpretation, but this was not wide enough to be accepted by one third of the patients refused. It is likely that restriction of the criteria for termination in general would simply lead to patients 'shopping around' other hospitals and making increased use of the private sector. Much of the revulsion aroused by abortion is no doubt due to the number of operations carried out in later pregnancy, i.e., over three months, and if these at least could be reduced the situation should be improved. In this series such cases were in fact recommended less often, and gynaecologists appear less likely to accept recommendations at this stage, as is understandable by reason of the physical risks alone. There might be a case for restricting the psychiatric criteria in these later cases, e.g., to major psychosis, serious suicidal risks, or those with a strong history of psychiatric illness. Although such a trend already appears to exist it should be easier to maintain if it were made more explicit.

Another modification that might be considered is the appointment of area panels to which patients refused termination could appeal, or even for initial referrals. The composition of such panels would be predominantly medical, but the addition of a member of the local Social Work Department would serve to acknowledge the fact that other than strictly medical factors are often involved. Such a step might help to prevent the tendency of some patients to seek repeated consultations until their aim is achieved. Those who were still refused after appealing should feel that their case had had a fair hearing, and would thus be more likely to come to terms with their situation. In addition, it should be possible to mobilize at an early stage all available sources of social support for those who continued with the pregnancy.

Summary

A survey is presented of all cases referred to Leverndale Hospital and the Victoria Infirmary, Glasgow, for consideration of termination of pregnancy in the first two years following the implementation of the Abortion Act (1967). In 1968–69, there were 38 referrals, and in 1969–70, there were 78. Abortion was recommended in 71·5 per cent of cases. There was a very low incidence of history of previous psychiatric illness. The commonest diagnosis made was reactive depression, usually the product of social stress and personality factors. Grounds for termination were found more often with increasing age of the patient, and in the married more than the single. Patients presenting after the third month of pregnancy are considered separately. Follow-up through general practitioners was made of the cases refused abortion, and one third were found to have obtained the operation elsewhere.

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