MEDICAL PRACTICE

Contemporary Themes

Psychiatric and Social Factors in the Abortion Decision

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British Medical Journal, 1974, 1, 229-232**Summary**

A total of 132 consecutive referrals for psychiatric opinion on termination of pregnancy were examined and followed up at nine months. Of these, 48 (36%) were refused and 44 of the 84 terminated were sterilized. Those recommended for abortion tended to be older, married, and to have children. They had used contraception more often and they showed more clinical psychiatric abnormalities. The group had numerous social problems, but these did not distinguish those terminated from those refused, nor were there differences in religious affiliation or duration of pregnancy. Most of those refused obtained an abortion elsewhere and only 25 of the original 132 had a live child. General practitioners were more likely to disagree with a refusal decision than with termination. Psychiatric, physical, and social sequelae were infrequent in both groups. Contraception before and after was inadequate in most patients.

Introduction

Most women are now aborted because "continuance of the pregnancy would involve risk of injury 'to their' mental health . . . greater than if the pregnancy were terminated." Also their "actual or foreseeable environment" may be taken into account.¹ Thus doctors weighing the merits of each case must consider the woman's psychiatric state and assess her social circumstances. This paper examines the process as it has been practised by

psychiatrists in a large general hospital and relates the findings to the decision reached and to the outcome nine months later. Of the many studies on the psychiatric aspects of abortion, most are not British and are difficult to relate to British culture and law, or precede the Abortion Act.² Of the few comprehensive studies since the Act, the most notable are a large study of refusals³ and another covering an area and population almost identical to the present one during the years immediately after the Act.⁴ Neither assessed psychiatric and social findings comprehensively. The other major British study covers terminations before the Act.⁵

Patients and Methods

The group comprised 132 consecutive referrals from all sources from mid-1971 to mid-1972. These requests for psychiatric opinion on termination of pregnancy were seen in rotation by four consultants. Since the Abortion Act the hospital gynaecologists have referred patients freely for opinion when social or "mental health" factors are the grounds for termination advanced by the patient or general practitioner. This proved to be most of the patients referred and therefore was probably representative of all terminations referred to the hospital by general practitioners, excluding cases in which the grounds advanced were purely medical.

A questionnaire covering general information, clinical and social findings, contraceptive history, and the decision reached, was completed by the consultant at the time of examination. The assessing doctor tends to show bias by labelling psychiatric disorder in those he recommends and *vice versa*. We hoped to diminish this by avoiding formal diagnoses in the questionnaire and asking instead about the presence or absence of specific symptoms. A follow-up letter was sent to the patient's family doctor nine months later, with a reminder two weeks after that if no reply had been received. No attempt was made to contact patients directly. In some cases there were ethical problems and many were mobile and could be traced only by the practitioner's records. We thought it was important to have the doctors

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retrospective views on the decision, in view of professional disagreements on abortion decisions.⁷

Results

Out of a total of 132 patients examined, 48 (36%) were refused termination. Of the 84 recommended and terminated, 44 were sterilized.

Age.—Those recommended for termination had a mean age of 31 years, and those refused a mean age of 24 years. In the recommended group 59 patients were over 25 and 25 under; while in the refused group 19 patients were over 25 and 29 under. The difference is significant ($\chi^2 = 12.0$, D.F. = 1, $P < 0.001$). Of those over 35 years, 90% were recommended for termination.

Marital Status.—In the recommended group, 53 were married, 25 single, and six widowed or divorced; in those refused, 15 were married, 38 single, and five widowed or divorced. There are significantly more married women in the recommended group ($\chi^2 = 12.3$, D.F. = 1, $P < 0.001$).

Parity.—Of those recommended 19 were childless and 65 had one or more children; of those refused 23 had no children and 25 were parous ($\chi^2 = 7.9$, D.F. = 1, $P < 0.001$). Among the parous women, the mean number of children for those recommended was 3.5, and for those refused 1.2.

Duration of Pregnancy.—During the investigation there was an informal agreement between the gynaecologists and the psychiatrists not to recommend termination in pregnancies over 12 weeks, except for compelling reasons. Of those recommended eight were more than 12 weeks, and of those refused 11. The difference is not significant, suggesting that such cases were not referred by practitioners or gynaecologists.

Religion.—Since 30% of Glasgow's population is Roman Catholic, nominal religious denomination was examined. Of the cases referred, 33 (25%) were Roman Catholic. This figure compares with 107 Roman Catholics in 340 consecutive female psychiatric admissions to this hospital during the same period. The difference is not significant. Of those recommended for termination 21 were Roman Catholic and 12 of those refused. Again, the difference is not significant. The results suggest that there are no differences in religious affiliation in those referred for opinion or in those recommended or refused.

Clinical Findings.—Those not recommended were more often rated as showing "no psychiatric symptoms" (table I). The positive symptoms were analysed by totalling the instances from questions 3 to 12 inclusive for each group (150 for the recommended and 39 for the refused) and applying the z test for instances which shows that the clinical score in the recommended group is significantly higher than in the refused ($P < 0.002$).

Social Findings.—As nearly all the patients had social problems of some kind, and many had multiple problems, the findings

were analysed in a similar way to the clinical findings (table II). The positive problems (questions 2-9 inclusive) were totalled and the z test for instances applied. Though marginally more problems were noted in the recommended group, there is no significant difference. The high proportion of desertions in the refused group is noteworthy ($\chi^2 = 6.7$, $P < 0.01$).

Contraception.—Reliable information was obtained in 118 cases (table III). The difference between those who had and had not used contraceptives is significant at the 0.02 level (χ^2 1 and 2 combined = 5.5). The alarming neglect of contraception at any time confirms the findings of Pare and Raven.⁸

TABLE II—Details of Social Findings in 132 Patients as Extracted from the Questionnaire

	Recommended for Termination (n = 84)	Refused Termination (n = 48)
Current financial problems	23	8
Financial problems (if pregnancy continues)	23	15
Problems with existing children (current or predictable)	28	8
Housing problems	20	9
Career and occupational problems	19	10
Desertion by spouse or putative father	18	21
Problems with immediate relatives (parents/husband)	31	15
Adultery/promiscuity	15	6
Total problems	177	92
Average problems	2.1	1.9
	z I = 0.73, Not significant	
No significant social problems	8	3

TABLE III—Use of Contraception by 118 Patients Recommended for and Refused a Termination

	Recommended	Refused	Total
Used conscientiously	18	4	22
Used irregularly	15	9	24
No contraception used at any time	38	34	72
Total	71	47	118

Follow-up

TERMINATION PATIENTS

Out of a total of 84 patients who were terminated at this hospital 44 were also sterilized. Replies to inquiries about all these cases were received from the patient's family doctor. Adequate information on outcome was available for 81 patients, but three had lost contact with the doctor. Inquiry was made about any consultations since termination and specifically about psychiatric complications, prescription of any psychotropic drugs, or referral to a psychiatrist or other hospital. Other questions concerned physical complications, social problems, contraception, and further pregnancies. Finally the doctors were asked to comment on the hospital decision, agreeing or disagreeing with it in retrospect.

Continuing psychiatric symptoms were noted in eight patients, but in only four of these did they seem to be sequelae. One middle-aged woman, terminated and sterilized and with five live children, developed mild continuing depression, expressing regrets that the operation had been done. In retrospect it emerged that she had had the termination at her husband's strong insistence and had had concealed mixed feelings at the time of the operation. In the second patient mild depressive symptoms persisted for some three months postoperatively and were successfully treated with antidepressants. In another patient mild depression persisted for two months, but disappeared without treatment. The fourth patient was a 16-year-old

TABLE I—Details of Clinical Findings in 132 Patients as Extracted from the Questionnaire

	Recommended for Termination (n = 84)	Refused Termination (n = 48)
Suicidal thoughts expressed	13	2
Significantly anxious	20	5
Significantly depressed	36	5
Other psychiatric symptoms	8	3
Family history of psychiatric illness	6	2
Previous psychiatric history or treatment	20	5
Previous termination	2	1
Previous illegitimate pregnancy	12	5
Physical or emotional immaturity	20	6
Personality disorder	13	5
Clinical score	150	39
Average score	1.80	0.81
	z I = 4.5, $P = 0.002$	
No psychiatric symptoms	4	20
Distressed, but not out of proportion to circumstances	24	23

illegitimate Roman Catholic girl of below-average intelligence who had sustained a severe head injury in childhood. She was referred for psychiatric opinion when 13 after frequent visits to the hospital casualty department with complaints of having been sexually assaulted which were found to be false. With strong pressure from her mother termination was carried out. Nine months later the patient was depressed, blamed her mother for forcing her to have the termination, and expressed much guilt about the operation. She was working despite these symptoms.

Of the 81 patients only 11 had had any kind of psychotropic medication prescribed, and only five were attending psychiatrists (four for pre-existing symptoms).

Physical complications were noted in six patients (two urinary infections, one haematoma in a wound suture, one venous thrombosis of the labia, one menorrhagia with irregular periods, and one case of pelvic inflammation requiring hospital admission).

Further pregnancies occurred twice. One patient was terminated for a second time, but by another hospital; the other patient presented herself to the family doctor within a year of termination, seven months pregnant, not seeking termination.

Severe social problems were recorded in nine patients. In one case the husband had deserted the wife, in another the husband was in prison and divorce proceedings had started. Both these situations had been envisaged at the time of the abortion decision. In the other seven patients severe social problems existing before termination continued unabated, but would probably have worsened if the operation had not been carried out. Only 14 patients had returned to the family doctor for contraceptive advice.

In 67 patients the general practitioner agreed with the decision without reservation; in three he was uncertain, and in 11 patients he disagreed. Not all gave explicit reasons for their disagreement. In three cases the doctors disagreed on conscientious grounds, and this was probably the reason in most cases where the doctor did not specify his reasons. In one case the doctor cited the physical complications that had ensued; another disagreed because of the patient's known promiscuity and the further pregnancy that resulted; and yet another felt that the termination had been sought by the patient as an act of revenge on her husband.

PATIENTS REFUSED TERMINATION

Of these 48 patients one was lost to the practitioner at follow-up. Of the remaining 47 only 25 continued the pregnancy to term. In 17 cases the mother kept the baby, in six the baby was adopted, and in two cases a final decision had not been made. Four patients were said to have aborted spontaneously and three obtained abortions under the N.H.S. elsewhere in the city. Of 15 patients who had abortions privately, 14 had them in England and one in Glasgow. Thus only 19% of the patients went to term and out of all 132 pregnancies only six babies were adopted. Of the 25 cases continuing to a live birth the doctor considered that the patient had accepted the situation in 23. One patient was unsure and one remained bitter and resentful.

There were definite psychiatric sequelae in only three cases, none requiring referral to a psychiatrist. A total of four patients received psychotropic drugs during the period of follow-up. There were no serious medical or obstetric complications. Social problems were significant in four cases. In two cases the psychiatric sequelae were depressive reactions provoked by the loss of a child at the time of adoption; the third was a depressive reaction when the patient was disowned by her parents. The social problems were related to family tensions in two cases, where the mothers of the patients required medical support during the pregnancy and were more upset by the situation than their daughters. In another case the girl married late in the pregnancy, and the marriage proved unhappy from the start. Lastly, the disowned girl faced severe social difficulties. Of the 25, eight subsequently sought contraceptive advice from the

family doctor, of whom two were sterilized, which was an undertaking given when termination was refused.

The doctors' views are more difficult to ascertain in this group. Many must have tacitly disapproved by arranging termination elsewhere. In the 25 cases resulting in a live birth, 16 doctors believed in retrospect that the decision had been the right one, three were unsure, and six disagreed, several strenuously.

Discussion

Those recommended for termination are older, more are married, and more have children than those who are refused. They have used contraceptives more often, if irregularly, and they are rated as showing more clinical psychiatric abnormalities. They do not differ from those refused in the number of social problems they show, in religious affiliation, or in duration of pregnancy. Those refused have more often been abandoned by regular boyfriends.

The group as a whole has many, and often multiple, social problems. Their frequency bears no relation overall to the decision reached. In comparison few psychiatric abnormalities are recorded, but those that are distinguish the two groups—especially ratings of distress or depression, or the recorded absence of psychiatric abnormality. Only 25 of the 132 patients had a history of psychiatric symptoms before the pregnancy and, though 41 were regarded as significantly depressed, only 15 expressed suicidal thoughts. Not only are psychiatric symptoms few but they are generally mild and a direct result of the pregnancy.

The follow-up shows (as do other published series) that most of those refused termination obtain it elsewhere. When the relatively small number proceeding to term is compared with those terminated there are no striking differences. Psychiatric, social, and medical sequelae as measured in terms of seeking medical help are small in both groups. There is no evidence of psychiatric complications of termination but cases of depression and appreciable social distress occur in the refused group. There is a substantial measure of disagreement between hospital and general practitioner whatever the decision made.

The only other large groups studied since the Act have been those of Todd,³ who reported 116 patients seen in this area of Glasgow some two years before the present study and ascertained the outcome in those refused; and of Beazley and Haeri,² who studied the 155 (15%) refused at a London hospital at about the same time. The present series seems to be the least "liberal" overall (table IV). Nevertheless, the trends which are significant for refusals in this series (more single, more younger, more first pregnancies) are seen in the others, especially in the series of Beazley's and Haeri. The comparison suggests that, whatever the degree of "liberality," the core of refusals is formed by young single women pregnant for the first time, and that it is in this group that differences of opinion and policy are most noticeable. Whatever the series and the policy, 80-90% of the patients succeed ultimately in obtaining termination. There may be financial deterrents, but both Glasgow series show that geography is no obstacle: when refused in Scotland, most travel to Birmingham or London for termination.

A survey carried out in Glasgow by no means reflects national trends. The city has many social problems, a large Roman Catholic population (lay and medical), and extreme differences of opinion among the medical profession about the interpretation

TABLE IV—Details of Patients Refused Termination in Three Series. Results Expressed as Percentage of Patients

	Todd (1971)	Beazley and Haeri (1971)	Present Series
Patients Refused	28 (n = 33)	15 (n = 155)	36 (n = 48)
Aged under 25	61	72	60
Single	51	77	60
No children	49	69	48
% of total group having live birth	16	8	19

of the Abortion Act, not only on religious grounds. Only 2% of terminations are carried out privately. The statistics issued by the Scottish Home and Health Department for 1970⁸ show that, for every termination carried out in Scotland, 1.71 are done in England and Wales. The figures for the western region of Scotland are the lowest in Scotland; for each therapeutic abortion there, 2.34 were done in England and Wales. These figures involve large numbers. For example, if in 1970 the rates for the rest of Scotland had been applied to the Glasgow area there would have been a total of 1,840 additional abortions during the year.

Conclusions

The "sticking point" in the abortion decision and the most controversial issue seems to be the single, abandoned, girl. This group accounts for the refusals, which explains the discrepancies between the low figures for the region and the higher figures for the rest of the country, and yet it is the group (or part of it) which remains in a series where 85% of requests were granted.⁹ It is the group most often terminated privately.⁹

The findings in this group show that, while social problems preponderate, the decisions are made on clinical psychiatric grounds—that is, whatever the severity of the social problems the patient is expected to show a severe reaction to them before termination is advised. While psychiatric sequelae are uncommon in terminated and untermiated patients they are marginally more frequent in those refused.

Some tentative conclusions about the operation of the Act are possible. Firstly, despite careful attempts at informed decision-making the bulk of women seeking an abortion achieve their end if not in one centre, then in another; if not under the N.H.S., then privately. Secondly, even when psychiatrists are making the assessment, social factors at best are given only secondary importance in reaching decisions, and at worst play no part at all. Thirdly, the hard core of dissent is the single girl. Probably this group provokes the most moralistic response from the profession.

Lastly, the study confirms the sad state of contraceptive practice among married and single women and older and younger women, both before and after abortion or unwanted pregnancy. Evidence from other sources¹⁰ suggests that this is unlikely to be remedied, and the number of unwanted pregnancies and hence of abortions is unlikely to decrease in future.

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Medicine in Old Age

Endocrine Disorders in the Elderly

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British Medical Journal, 1974, 1, 232–236

Any endocrine abnormality except those affecting menstruation may occur in old people, and many middle-aged people with treated endocrine disease live into old age. Some glandular disorders are common in the elderly (for example, thyroid disease and diabetes mellitus), but the only certain hormonal "disease" of old age is the decline in gonadal function—which happens quickly in women at the menopause and more slowly in men in later life. We do not know whether this inevitable ovarian and testicular failure causes ageing of other tissues, though possibly women who have an abnormally early menopause have a shorter life expectation than other women. Probably one reason for the long survival of women compared with men (some five years more, on average) is a protective effect of female hormones from menarche to menopause. Unfortunately we do not have any hormonal therapy which can prevent ageing in either sex by replacement of sex hormones given from middle

age onwards, or starting in old age. There is no justification for giving female hormones to men to prevent ageing. The use of oestrogenic hormones in elderly men with prostatic carcinoma is associated with a very substantial risk of thromboembolic disease and fluid retention. Therapy with sex hormones in older people may prove useful in the prevention and treatment of osteoporosis (Nordin¹ has reviewed possible reasons for postmenopausal calcium loss) and help alleviate arthritic and inflammatory conditions by interfering with prostaglandin synthesis. These are fascinating speculations but it is much more important to discuss the problems of diagnosing, investigating, and treating "classical" endocrine syndromes affecting old people.

Endocrine syndromes may present at any age with a florid picture of hyperactivity (for example, exophthalmic thyrotoxicosis) or hypoactivity (for example, hypopituitarism). Nevertheless, these are rare in very old people, probably because of the way endocrine dysfunction tends to have widespread and non-specific effects, the modifying effects of other accumulated pathologies, and multiple prescribing. The second and third factors are very common in old age and both modify target-organ response and laboratory tests. Our inpatients have an average of almost one endocrine "problem" each, classifying problems as proved endocrine diseases and abnormal endocrine function tests without apparent disease. Over half are receiving three or more drugs. The problems of interpreting the results of

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