ABORTION AND THE PSYCHIATRIST

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The medico-legal aspects of abortion in England are still governed by the Criminal Abortion Act of 1861. It is an offence to procure or attempt to procure an abortion, and anyone doing so is guilty of a felony. The law regarding therapeutic abortion is not so clear. Both Davidson (1957) and Hadfield (1958) adopt a cautious attitude. The latter quotes the case of *Rex v. Bourne* (1938), when it was allowed that an abortion, because it was thought necessary in the interests of the mother's health, was lawful. Since then, what is likely to lead to serious impairment of the mother's mental health has been freely interpreted and has depended as much on the personal attitude of the psychiatrist and the social climate as on established clinical facts. In other European countries the situation is no less equivocal, and Bleuler (1924) states: "In the Protestant part of Switzerland the sensibilities of the people demand an attitude that is more favourable to abortion, and I should let social considerations count with the legal. Plain legal determinations exist nowhere: one has to fall back on local and customary interpretations. . . ."

In Sweden the situation is more clearly defined in that five grounds for termination are listed (Ekblad, 1955). These are: (1) medical, (2) medico-social, (3) socio-medical, (4) humanitarian, and (5) eugenic. Yet the strictly medical indications are no more positive than in England, and the impression is gained that the law in Sweden merely gives the doctor a wider field in which to manoeuvre.

The main issue facing the psychiatrist is whether the mother is likely to develop a puerperal psychosis and the effects of such a psychosis on her future health, though the question of suicide during pregnancy is also often raised. Some psychiatrists concern themselves with minor grades of morbidity, others with the possible effect on the unborn child or existing children; but the ultimate decision to terminate is the responsibility of the gynaecologist, and most would not operate unless they were advised that the mother would almost certainly suffer permanent mental damage of a serious nature or would commit suicide.

Davidson (1957) considers that abortion on psychiatric grounds is increasing, especially when compared with abortion for organic disease. He quotes the figures from the Middlesex Hospital from 1951 to 1954, when out of 46 therapeutic abortions 30% were on psychiatric grounds. Calderone (1958), from a much larger series (1,309 therapeutic abortions between 1951-3), quotes 37.8% on psychiatric grounds, compared with 13.1% out of 3,046 therapeutic abortions between 1943 and 1947. It is unlikely that this increase could have been due to the greater incidence of strictly psychiatric indications, or to any new information which might suggest a more grave prognosis in puerperal psychosis. One suspects that socio-economic factors were probably the main consideration.

Serious doubts have been expressed whether these factors come within the province of the psychiatrist, and Donnelly (1958) states in the Calderone (1958) symposium: "As medical men, I believe we should definitely confine our indications for therapeutic abortion to strictly medical reasons. . . . We should be doctors of medicine, not socio-economic prophets. How many students in medical school to-day who were born in the depths of a depression in

1932 were good socio-economic risks at the time of their birth? If we could go back three or four generations in any of our families and eliminate all the poor economic risks among our antecedents, this conference to-day might never have been convened."

Indications for Termination.—Psychiatric indications for termination should not be based on sentimental guesses but on a strong body of facts. The following questions should be carefully considered by the psychiatrists: (1) Is a puerperal psychosis likely to develop? (2) What would be its outcome? (3) What are the chances of avoiding it by termination of the pregnancy? (4) What would happen if patients who according to present-day practice would be aborted were left alone? (5) What are the risks to the mother's mental health of a therapeutic abortion?

Previous Studies

Studies on substantial numbers of patients with puerperal psychoses have been reported by Ellery (1927), Zilboorg (1928), Solomons (1931), Anderson (1933), Cruikshank (1940), Skottowe (1942), Hemphill (1952), Tetlow (1955), Polonio and Figueiredo (1955), Schneider (1957), White *et al.* (1957), and Martin (1958). Although there are some differences in the conclusions drawn by these authors, there is also a wide measure of agreement, particularly over symptomatology. Anderson (1933) in a carefully controlled clinical study found nothing significant in the pre-morbid personality structure of his patients with puerperal psychoses, compared with a matched group of patients suffering from psychoses not associated with childbirth. Others have stressed the similarity of the symptomatology and insisted that, apart from the delusional content which may be concerned with the child, there is nothing to distinguish these states from other acute psychotic breakdown, such as post-operative states.

Estimates of prognosis by these authors vary widely. Ellery (1927) reports 49% of recoveries in his most favourable prognostic group; Hemphill (1952) in his unselected total of 116 cases had 80% recoveries, and his series included 19 patients with schizophrenic reactions, of whom only one recovered. Martin (1958) had 86% recoveries in her group of 75 cases, which included 15 schizophrenic reactions, suggesting that the prognosis in schizophrenic reactions is not as poor as was initially thought. She emphasized that the condition was not a common one and that a large series could be built up only over a period of years and that prognosis was likely to be improved by advances in treatment. It has also been alleged that the condition is not now so malignant, and the above figures would support either of these conclusions.

Present Study

Since 1951, patients referred to the author because of instability in pregnancy or with puerperal psychosis have been studied to assess the predictability of puerperal psychosis in the former group and the outcome of puerperal psychosis in the latter. As there were no clear psychiatric indications for termination of pregnancy, this was not recommended in those presenting with instability. In its stead, psychiatric supervision or treatment was offered. As in most instances the patients were referred

for termination only, relatively few accepted the offer, and, after a short time, requests for termination on socio-economic grounds were greatly reduced. A number of

Background Factors in Puerperal Psychoses

Family history	114 (53.5%)
Instability in childhood	124 (58.2%)
Previous history of mental breakdown	94 (44.1%)
puerperal psychosis	59 (27.6%)
Instability during pregnancy	29 (13.6%)

FIG. 1

patients with a previous history of puerperal psychosis or who showed frank psychotic features during pregnancy continued to be referred, so it was possible to learn what happens to such patients if one does not recommend termination.

Over a 12-year period 213 patients with puerperal psychoses were investigated and treated. Data concerning age distribution, age at marriage, number of children, family history of mental breakdown, previous puerperal psychosis, and history of instability during pregnancy are presented in Figs. 1 and 2 and the Table. In order to broaden the inquiry, the case records of patients with puerperal psychoses who had been admitted to

FIG. 2

five regional mental hospitals were studied and the data on age distribution and age at marriage are also presented in Fig. 1.

A remarkable negative finding which is not presented in the tables was the total absence of unmarried mothers in the United Birmingham Hospitals series. This absence could not be explained by pre-selection, and, furthermore, when age at marriage was compared with the age of the

first-born child, all had conceived in wedlock with the exception of one Jamaican patient. Ordinarily, in a series of 213 births one would expect 6-8% to be illegitimate, giving a total of approximately 14 unmarried mothers. Among the 100 patients who developed a puerperal psychosis after the first pregnancy one would have expected 20 to have conceived out of wedlock; but there was only one.

Clinical Data

Symptomatology.—The clinical features were predominantly those of depressive psychoses, though schizo-affective reactions accounted for 15% of the total. Purely schizophrenic and manic reactions were extremely rare and accounted for only six and three patients respectively.

Patients with Leucotomy.—Four patients had had leucotomy for persistent psychotic states of a schizo-affective nature which had followed a previous pregnancy. These patients' mental states were still unsatisfactory, but in no instance did the subsequent pregnancy aggravate the psychotic state, and in two patients there was marked improvement after pregnancy and childbirth. A fifth patient with persistent amenorrhoea and a crippling obsessional state improved markedly after leucotomy (bilateral undercutting of areas 9 and 10) and subsequently menstruated, became pregnant, and had her child with no psychiatric sequelae. Later she gave birth to twins, again with no ill effects.

Schizophrenic Mothers

There were 17 such patients, of whom 10 had shown schizophrenic features prior to childbirth and 7 after. The latter group were invariably schizo-affective reactions, and though 15% of the whole series could be thus labelled, the schizophrenic mothers were those in whom the schizophrenic element predominated. The prognosis in this group was generally more favourable than one would have expected in patients with a similar symptomatology but occurring outside a setting of pregnancy.

One patient (who precipitated this inquiry) had been in a mental hospital for 18 months with a schizophrenic psychosis after childbirth. As she was not improving, her husband requested, and accepted, responsibility for her discharge. She soon became pregnant, and the question of termination was raised, but the patient refused. The alternative of using statutory powers was so unattractive that it was decided not to interfere, and it was also argued that her mental state was so poor that childbirth could not cause much deterioration. After delivery she improved and lost most of her psychotic features, and after a follow-up period she enjoyed a full remission. Some years later she had another baby without any adverse sequelae.

Other schizophrenic mothers with equally gross degrees of morbidity were allowed to go to term, and follow-up has shown that in no case was there deterioration of symptoms, while in some there was a complete remission. In one patient (referred by my colleague Dr. R. W. Tibbetts, and not included in this series) the schizophrenic features had followed childbirth and were resistant to treatment, including prefrontal leucotomy. She became pregnant again, was allowed to go to term, and her mental state after childbirth was much improved.

Martin's (1958) contention that with advances in treatment the prognosis should improve seems to be borne out, for with the introduction of the phenothiazines, schizoaffective and schizophrenic reactions are more readily controlled and the former, which at one time required in some instances prolonged courses of electroplexy, now remits more readily.

Predictability.—If the development of a puerperal psychosis is to be regarded as a material factor in deciding on therapeutic abortion, then it is important to be able to predict its occurrence. In the past a variety of factors, such as sepsis, haemorrhage, and sexual guilt, have been considered significant, only to be later proved invalid. A classic example of such proof was that of Anderson (1933), who analysed Zilboorg's (1928) thesis that puerperal schizophrenia was a result of a castration complex of the revenge type with anal aggressive features. He used non-puerperal controls to show that there was no substance to Zilboorg's claim, and ideally any factors which are being studied should be treated similarly. In the present large series, matched controls were not used and therefore any conclusions must be less significant. The factors investigated were those which are generally accepted as having some bearing on the development of a puerperal psychosis, and included those data presented in the Table.

Family History of Mental Illness.—The incidence of 53.5% of puerperal psychotics with mental illness in a near relative is significantly high. The severity of this mental illness was at least one psychotic episode requiring treatment—suicide or attempted suicide, and in one instance admission to Broadmoor for homicide.

Instability in Childhood.—Lower grades of morbidity were the rule here, and consisted of undue shyness, timidity, and fears of the dark. The incidence was high (58.2%), but this instability did not extend into adolescence or adult life, and school and employment records were generally above average.

Previous History of Breakdown.—The severity of breakdown varied considerably. In 24 patients (11.3%) it was as severe as in the presenting puerperal psychosis and was precipitated by such factors as bereavement, operation, influenza, miscarriage, and "therapeutic" abortion. In the remaining 70 patients the morbidity was not gross and consisted of phobic states, mild recurring depression, and cyclothymia.

Previous Puerperal Psychoses.—These, which were present in 59 (23%) patients, were generally as severe as the presenting illness, and in five patients more than one previous attack was noted. The most remarkable aspect of patients with previous puerperal psychoses was the difficulty, if not impossibility, of forecasting a further breakdown. Reference has already been made to the schizophrenic mothers who had no further breakdowns with subsequent pregnancies. One patient who had a psychosis after the birth of her first and third children had no trouble after the birth of her second and fourth. Another patient had a severe depressive psychosis after her first four planned pregnancies. She recovered completely on each occasion with a course of electroplexy, but at the age of 43 she accidentally became pregnant and the question of termination was raised. She was a very conscientious person, and the risk of a post-abortion psychosis had to be weighed against the risk of a fifth puerperal psychosis. In our experience the former tended to be more malignant and its iatrogenic element did not make treatment any easier. The position as it was then understood was put to the patient, the husband, and the

family doctor, and a second opinion was offered. They elected to continue with the pregnancy, and this time there was no puerperal psychosis.

Because of the very favourable prognosis in puerperal psychoses many patients who had an episode and who inquired about the risk of subsequent pregnancies were not discouraged and the vast majority had no trouble.

Instability During Pregnancy.—Patients who were referred for termination because of instability during pregnancy scarcely ever developed a puerperal psychosis. Unless the presenting instability was of a psychotic, especially schizophrenic, nature, one could confidently predict that a puerperal psychosis was most unlikely.

Abortion as a Therapeutic Agent.—It is an axiom in medical practice that a measure designed to avert a situation should not in itself precipitate such a situation. Ekblad (1955) found in his series of 479 patients who were aborted on psychiatric grounds and in whom the morbidity was not generally gross that 11% had undesirable sequelae of a psychiatric nature, and concludes: "The psychiatrically abnormal find it more difficult than the psychiatrically normal to stand the stress implied in a legal abortion. This means that the greater the psychiatric indications for a legal abortion are, the greater will be the risk of unfavourable psychic sequelae after the operation." Siegfried (1951) found 59% of guilt reactions in his series of therapeutic abortions, while Polonio and Figueiredo (1955) report that out of 244 "puerperal" psychoses 20% occurred after spontaneous abortion. In the present series eight patients had a history of a post-abortion psychosis, of whom four had spontaneous and four had therapeutic abortions.

Pregnancy and Suicide

It has often been suggested that a puerperal psychosis or instability in pregnancy greatly increases the risk of suicide and that this aspect should be given due consideration. It is commonly put forward by the patient, relatives, and even the family doctor as the strongest argument in favour of termination. Lindberg (1948) reported on 304 women who were refused legal abortion and of whom 62 indicated they would commit suicide; none did. It is not known, however, how many (if any) of the 62 had subsequent criminal abortions. Dahlgren (1945), in a study on suicide and attempted suicide, found that 3.7% of the women were pregnant, which would suggest that a pregnant woman can attempt suicide, though very few are successful. As part of the present inquiry, the Coroner of the City of Birmingham was asked for information concerning suicide in pregnant women, and the following reply was received:

"... I can now tell you that my staff have gone through the 119 cases of suicide of females up to the age of 50, 22 of whom were unmarried. They date from January, 1950, up to to-day, 8th November, 1956.

"I can now summarize our research as follows: In no case has pregnancy been established as a factor in bringing about the suicide. In two cases the woman thought she might be pregnant, but it was certainly not confirmed by medical examination or post-mortem examination. We have no record of any woman known to be pregnant having committed suicide."

The Unmarried Mother

Social stress is often suggested as a potent factor in precipitating a psychosis of pregnancy or suicide. The latter event, as has been pointed out, is rare enough not to be a serious consideration. It can even be argued that

pregnancy reduces the overall risk of suicide compared with a population that is not pregnant. In the present series of 213 patients none was unmarried. Among the mental hospital population of 97 patients two were unmarried, one being hysterical and of limited intelligence rather than psychotic, while the other was schizophrenic before pregnancy.

If one were asked to describe the personality of the patient who developed a puerperal psychosis one could supply the following formula:

She is almost certainly married, with a moral code which denies premarital intercourse. She marries reasonably young and in this respect does not differ from her peers. Her school and employment records are effective and on the whole above average. Her personality is usually pleasant and she enjoys considerable popularity with her friends and neighbours. The baby is generally planned and she is a good mother. She tends to be a little overconscientious and therefore takes more than her share of the social responsibilities of the community. Her family too are of this stamp, and this will be reflected in their incidence of mental breakdown, which is usually of a depressive nature. She may show a degree of vulnerability to the commoner precipitating factors of breakdown, such as bereavement, infection, operation, and childbirth.

As the incidence of puerperal psychosis is one per thousand live births it is difficult to accept that among the other 999 women there are not many similar personalities. The 15% who show schizo-affective reactions do not differ significantly from the others in their background. There will probably be no adverse physical or obstetric factors in the patient's background. The time of onset of the psychosis is usually not in the puerperium as defined by the obstetrician—namely, the 10 days following childbirth—but in the 6th to 12th week, and consequently very few are referred from maternity hospitals.

Prognosis

This continues to improve, and in the present series no patient suffered permanent mental damage as a result of her puerperal psychosis. Even those who were schizophrenic prior to pregnancy did not deteriorate, and in the vast majority of cases recovery was rapid. The babies thrived and maternity and child-welfare reports showed no handicap.

Discussion

There is a parallel between the role of the psychiatrist in abortion and his role in court in cases of capital murder. In the latter instance, society had less and less inclination to hang, yet the court was bound by the McNaughton Rules, and the psychiatrist was expected to provide a formula whereby the accused could receive the verdict of "guilty but insane." There were many unseemly wrangles over these Rules and psychiatrists were frequently committed by the defence to go further than the clinical facts would permit in order to save society from a disagreeable task. With the passing of the Homicide Act, 1957, and the reduction in the number of offences requiring the death penalty, as well as the acceptance of diminished responsibility, one now rarely sees these battles over the McNaughton Rules and the accused's "defect of reason." The truth has come out; it was not the Rules that society objected to so much as hanging.

Similarly with abortion, there is considerable pressure to make it easier, if not legal, and psychiatrists are expected to disregard the clinical facts in order to satisfy a desire for a social reform. It cannot be to prevent mental illness, for abortion is not a prophylactic against psychosis but

rather a precipitant. It is essentially a socio-economic problem with the psychiatrist being exploited, for he at present provides the most convenient way round the legal situation. The only proper role for the psychiatrist, should abortion become legal, would be to help decide who should not be aborted. He should stick to clinical facts in his practice of medicine, and these are clear and unequivocal. Whether at other times he campaigns for reform in the law relating to abortion is his own private business, but he should not distort medical facts to serve other ends. As Taylor (1958) in the Calderone symposium states: "If you are going to find medical reasons for aborting 750,000 per year in the U.S.A. there is a medical reason for aborting anybody."

Summary and Conclusions

A study of 213 patients with puerperal psychosis showed that the condition carries a good prognosis and is virtually unpredictable.

Instability in pregnancy does not contribute materially to the incidence of puerperal psychosis.

Suicide is less of a risk in pregnant women than in non-pregnant women.

Unmarried mothers are relatively immune from puerperal psychosis.

Abortion, even if therapeutic, may in itself produce a psychosis.

There are no psychiatric grounds for the termination of pregnancy. Pressure may be brought to bear on the psychiatrist to recommend termination. He may be told the patient is threatening suicide or be regaled with the dreadful social consequences. The answer is still not to recommend termination, which may indeed be harmful, but to nurse the patient through her unstable phase.

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