

Psychiatric Issues in Therapeutic Abortion

HENRY D. LEDERER

*Department of Psychiatry, Medical College of Virginia,
Richmond 23219**

At this moment in the history of American medicine a complex of problems, decisions, and new courses of action faces the medical profession in the matter of therapeutic abortion. In response to the hidden, pandemic occurrence of an estimated one million illegal abortions each year; to the evidence of a population explosion; to the ambiguous interpretations of abortion statutes given by many attorneys, ranging from general to restrictive; and to new, broader concepts of health and illness involving social and economic dimensions, the American Law Institute, the American Medical Association, the American Academy of Obstetrics and Gynecology and the American Psychiatric Association have issued position statements recommending revision and liberalization of the statutes in various states. As a result North Carolina, Colorado and California have modified their codes in the directions recommended, and legislative commissions in other states are studying the issue. Essentially, these new statutes constitute legislative sanction for therapeutic abortions which have been performed in modest numbers for many years by competent physicians in officially accredited hospitals.

For the purpose of this discussion I should like to focus your attention on the psychiatric involve-

ment, questions, dilemmas, and opinions concerning therapeutic abortion. Under most of the existing statutes, therapeutic abortion is only permitted to preserve the life of the mother. Therefore, within the context of strict interpretation, the sole psychiatric indication is a high probability of suicide by the pregnant patient. A few statistical studies have been conducted on the incidence of proven suicide in pregnant women. These data show a significantly low frequency; moreover, an absence of suicides has been reported in several series of women who were refused abortion.

When we couple these statistical studies with the extensive range of psychiatric treatment methods which we can offer depressed, suicidal persons, this major psychiatric indication for therapeutic abortion to preserve maternal life diminishes almost to the vanishing point. However, when making a decision in a singular situation with a particular patient, a psychiatrist might, in good conscience and with competent professional judgment, recommend abortion to reduce the probability of suicide.

I think it highly important that the non-psychiatric physician be aware that: (1) Suicide risk is low in pregnant women; and (2) Suicidal risk can be treated psychiatrically in many ways rather than aborting the pregnancy. Therefore, it seems prudent for the non-psychiatric physician to refer to a competent psychiatrist the woman demanding abortion and backing her demand with suicide threats.

* Present address: Division of Intramural Training, National Institute of Mental Health, St. Elizabeth's Hospital, Washington, D. C. 20032.

Such referral should be for consultation rather than for specific recommendations for abortion. Reciprocally, it seems proper for the psychiatrist to clarify that his position is as consultant rather than as the man with the rubber stamp.

Actually there are bigger, unresolved problems which raise the following question: Does therapeutic abortion help preserve maternal mental health, or does it threaten and/or damage maternal mental health? It is of considerable relevance for us to gather information to answer this question. Psychiatrists and other physicians entertain strong convictions and opinions about the mental health sequelae to therapeutic abortion, but they have not conducted systematic studies to check their impressions.

Gladston (Calderone, 1958, p120) expressed the view that therapeutic abortion has serious deleterious effects upon the patient when he said: "Drawing upon my experience I would summate the major psychological effects in three terms: frustration, hostility, and guilt." He also believed that, "Bad as the situation was initially it not infrequently becomes worse after the abortion" (*Ibid.*, p119). Kane and Ewing (1968, p205), in a thoughtful review of the literature, stated, "There seems to be little in the literature indicating that benefit to psychiatric patients from a therapeutic abortion will occur on any but a chance basis." Simon, Senturia and Rothman (1967) proposed the thesis that therapeutic abortion provides an opportunity for neurotically ill women to act out their aggressive and self-punishing fantasies, i.e., abortion would reinforce serious psychological conflict areas in women who request abortion for psychiatric reasons.

Jansson (1965, p110), in a study of post-abortion patients who were admitted to mental hospitals, concluded: "We have thus the paradoxical situation that it is in the cases in which a legal abortion can best be justified from the psychiatric

standpoint that the risk of a mental insufficiency during the post-course is greatest." The efficacy of therapeutic abortion as psychiatric treatment was questioned.

In contrast, Höök (1963) reported increased proneness to psychiatric reactions in patients whose applications for abortion were denied. To add to the confusion of findings, Lidz (Calderone, 1958, pp125-128) has treated women who were not granted abortions and who subsequently were not ill but, rather, grateful that the pregnancies went to term. This author stresses that there is a tendency to underestimate the ability of most women to accept their babies and that ideas of inadequacy in caring for one's baby can be successfully dealt with in appropriate psychotherapy.

Various reports from Scandinavia and East Germany do not support the impression of deleterious psychological effects from abortion. In the American literature, Kummer's (1963) study of the experiences of 32 psychiatrists in Los Angeles revealed that 75% of this group had never seen a patient with severe or even moderate psychiatric sequelae to abortion, and the remaining 25% had rare contacts with patients suffering post-abortion mental symptoms.

Although the recommendations for more liberal statutes give justification for abortion in order to preserve the mental health of the mother, many psychiatrists consider abortion a necessary factor also for preserving the mental health of certain families and preventing future mental illness in unwanted children. These psychiatrists champion very liberal and permissive abortion laws similar to those of Scandinavia, West Germany, Israel, Great Britain and Switzerland, where socioeconomic difficulties are accepted as determinants of mental health. Schwartz (1968, p104) expressed this point of view as follows: "Although psychiatry may not be able to influence large numbers of parents to do a better job

of bringing up their children, there are, nevertheless, indirect ways that society can strengthen family functioning. One of the most important of these is by making it more readily possible for people to control the number and spacing of their children. Because effective contraceptive knowledge and services are not yet universally available to all segments of the population, countless unwanted children are born each year to parents who are not well motivated to provide adequate care." Schwartz cites Karl Menninger's statement "The unwanted child becomes the undesirable citizen, the willing cannon-fodder for wars of hate and prejudice."

The aforementioned group of prevention-minded psychiatrists further favors therapeutic abortion because of the existing inadequate care and provisions for illegitimate children. They point to the serious shortage of adoptive and foster home families, as well as to the demonstrated pathogenic consequences of institutional life for children. Schwartz (1968, p106) summarized: "The psychiatric and social problems associated with unwanted and unplanned pregnancies, and their aftermath, unloved and neglected children, create substantial suffering in our society. Many of these problems could be prevented by adequate contraceptive measures and, where these are inadequate, by judicious use of therapeutic abortion." Bowlby (1951, p157) said, "Deprived children, whether in their own homes or out of them, are a source of social infection as real and serious as are carriers of diphtheria and typhoid. And just as preventive measures have reduced these diseases to negligible proportions, so can determined action greatly reduce the number of deprived children in our midst and the growth of adults liable to produce more of them."

To date, no studies have been undertaken which evaluate the effects of therapeutic abortion or

denial of it upon family functioning and relationships. If it be correct that, following abortion, a mother suffers from frustration, hostility and guilt, how do such emotions reverberate throughout the family system? What happens in the marital relationship? How does the mother treat her living children? Do they become the vehicles through whom she overcomes her guilt, or are they the targets of her hostility? Does the family become more stable and function better, as the advocates of spaced and planned parenthood assume? Through careful attention to these and other questions about the family, we could begin to know in depth the psychotherapeutic or psychonoxious consequences of abortion.

The need for extensive studies is again indicated in those cases of therapeutic abortion performed because of rape or incest. Most persons agree that these two indications for abortion carry tremendous psychological hazards and constitute severe traumas. To date, I know of no follow-up studies of these patients and their families in the post-abortion period, although it would seem obvious that such studies should be made. A similar lack of well-documented and well-constructed follow-up studies exists concerning women aborted because rubella or other causes have raised the possibility of a defective birth. It is quite possible that in the rubella group one might find many patients experiencing post-abortion depression, guilt, frustration and anger.

At present and in the near future, as more states liberalize their abortion laws, there will be opportunities for conducting adequate psychiatric studies on patients and their families, so that we can replace our impressions with solid facts. Hopefully, in such studies particular attention will be paid to the effect upon the marital relationship and upon the husband as well as the patient. In reviewing the existing literature, one finds only

rare mention of the husband and prospective father and his attitudes, responses to, and behavior following abortion.

In the face of so many inconclusive findings and such incomplete information, what can be recommended by psychiatrists concerning the issue of therapeutic abortion and the problems of practice associated with abortion? The first matter to consider is the availability of psychiatric examination. The proposed modifications, as well as the existing codes in North Carolina, California and Colorado, are so constructed that only a very select segment of the population can afford a therapeutic abortion. These codes require examinations of the patient by at least two consultants as well as a general physician or obstetrician. In California the costs for such preliminary study have been sizeable and can only be borne by affluent families. Consequently, neither has the goal of reducing illegal abortion been achieved in the few states with liberalized codes, nor has the number of therapeutic abortions been increased. It is clear that psychiatric examinations should be made accessible through clinics and hospitals servicing the less affluent population, and, furthermore, that this population group must be informed of possible services.

A second psychiatric issue is the need to provide adequate treatment following abortion. If an abortion is granted for mental health and the stability of the family, then it is evident that proper arrangements must be made for helping the patient and her family accommodate to the stress of the abortion. It is medically naive to think that an abortion per se constitutes a form of psychiatric treatment and can establish at once a well-functioning, steady state in the patient and her family. It has been my impression that little or no planning for psychiatric attendance in the post-abortion period has been made. In our own hospital, no therapeutic

abortion is even considered for psychiatric reasons unless there is an associated plan and arrangement for follow-up psychiatric care. This practice is in response to the type of situation discussed earlier in which those patients for whom therapeutic abortion seems indicated because of high risk to the mental health were found to be the very ones most likely to react with symptoms to the stress of the abortion. In other words, the patient with meager ego resources is most likely to respond pathologically to a full-term pregnancy or to an abortion. Under these circumstances she is very much in need of adequate psychiatric care before, during and after abortion.

A third and related matter is the recommendation that more medical and psychiatric attention be directed to the husband and the family of the abortion candidate. Possibly as a result of the present use of the medical model—of the one-to-one relationship between doctor and patient—most consideration has been directed to the pregnant woman, with only tangential and secondary consideration of her family system. All of the proposals from the legal, medical and psychiatric associations reflect this latter omission. However, present-day psychiatry is rapidly developing a body of concepts and practices concerning family functioning and dysfunctioning in many situations of emotional and mental stress. It is strongly recommended, therefore, that in all cases in which there is a petition or permission for therapeutic abortion, evaluation and—where indicated—therapy should be provided for the family. This recommendation calls for the possible assignment of other mental health professionals, such as psychiatric social workers, to active participation in the total medical responsibility in therapeutic abortion.

A fourth consideration is the recommendation that the psychiatric arm of the medical profession

prepare itself for the eventuality that all abortion laws may be rendered invalid through Supreme Court decisions. Many students of the legal aspects of therapeutic abortion have stated that the abortion laws might be challenged on the basis of the Supreme Court decision regarding the Connecticut laws against contraceptive prescription. As you will recall, the Court based its decision on a new interpretation of basic human rights postulating a human right to privacy. Under such an interpretation, the whole issue of abortion may be considered a private matter between a marital couple and their physician. It is seriously anticipated that a test case may be forthcoming in the near future. In the event of such a change, psychiatric consultation may be neglected because of the ease with which legal abortion might then be obtained. From the studies that have been reported, it is clear that mental health evaluation is needed for the average patient undergoing therapeutic abortion and that decisions must be made for proper treatment where indicated.

It would seem that the medically honest course for all physicians who either participate in or deny therapeutic abortion would be to pursue sophisticated and sufficient re-examinations of these patients and families. These follow-up studies might provide us with information that would help define much more exactly the psychiatric indications for and contraindications to abortion, as well as rational treatment programs when such are needed. In this way, we could contribute toward advancing the situation which Freud (1962) said "would be one of the greatest triumphs of humanity, one of the most tangible liberations from the constraint of nature to which mankind is subject, if we could succeed in raising the responsible act of procreating children to the level of a deliberate and intentional activity and in freeing it from its entangle-

ment with the necessary satisfaction of a natural need."

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