A SURVEY OF PATIENTS REFERRED FOR THERAPEUTIC ABORTION ON PSYCHIATRIC GROUNDS IN A CAPE TOWN PROVINCIAL HOSPITAL

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Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Philosophy.

UNIVERSITY OF CAPE TOWN

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A B S T R A C T

The aims of the study were (1) to seek to isolate those features which distinguished patients in a group recommended for therapeutic abortion on psychiatric grounds from those who were refused such recommendation; (2) to isolate those factors in the psycho-social history which appear to have influenced the decisions made and (3) to conduct a follow-up study of both groups in order to study the late sequelae of the decision. A total of 197 patients were referred to a special clinic run by the Department of Psychiatry of Groote Schuur Hospital for assessment for therapeutic abortion on psychiatric grounds over the period 1/2/74 - 31/5/75. Extensive psycho-social and psychiatric data were collected on each patient. Some of these variables were submitted to a chi-square and a discriminant analysis. At follow-up 12 - 18 months after initial presentation, further demographic data was obtained and each patient completed a questionnaire on her initial and late reactions to the whole experience considered retrospectively. Results revealed that the main factors in the decision making were (1) need for referral for psychiatric treatment after the interview (this weighted in favour of termination), evidence of ambivalence over the pregnancy and/or abortion (this weighted against termination) and more than one intimate relationship (this weighted against termination); (2) at follow-up of the patients refused and recontacted, 45% did not carry their pregnancies through to term and (3) there was more evidence of disturbed behaviour in the termination group, but with regard to the emotional reactions, depression, for example, appeared to recede with the passage of time equally in both groups. The significance of the findings of this study as regards the whole problem of psychiatric assessment for the termination of pregnancy, is discussed.

SUMMARY

Introduction

The problem of an unwanted pregnancy is one of the stresses to which many women are exposed and to which they react in a multitude of individually different ways. Changing situations have resulted in a need to re-examine laws relating to abortion of various countries in the world over the past decade. Five main factors have prompted this need (Gardner, 1972).

1. A new awareness of the distress of unwanted children and of those born with congenital abnormalities.
2. Concern for a growing world population and needs for control in the face of limited resources.
3. A growing realization of the extensive practice of illegal abortions.
4. Safer and more effective abortion procedures.
5. Lack of unanimity among medical personnel about the indications for therapeutic abortion.

There are two extreme attitudes towards abortion. On the one hand is the approach that under no circumstances must any pregnancy be terminated, and on the other hand, that it is solely the choice of the mother and is a natural and legitimate extension of contraception. Although there is widespread support for this latter approach, Gardner (1972) points out two facts which should be recognised:

1. The woman does not in fact know what is involved in such a decision. She cannot know the risks of operative complications or likelihood of future conception. She cannot be sure of the reactions of her family. She cannot know what the response of her own conscience will be post-operatively and in later life.

2. If she is to make such a decision, she must do so quickly and at a time when she is least capable of doing so. At a time like this, women are apt to strongly deny their feelings of guilt and ambivalence in their determination to obtain an abortion.

On the other hand, there is the fear that abortion on demand might lead to a higher incidence of unwanted pregnancy. Illegal abortions still continue in countries where laws have been liberalized, although the number of septic abortions and deaths from abortion have declined. For some, even though an act is made legal, it does not necessarily become ethical.

There are wide differences of opinion among psychiatrists about many aspects of abortion, particularly the sequelae of abortion or refused abortion. During the period 1940 - 1959, the data presented focussed on the damaging effects of therapeutic abortion (Simon and Senturia, 1966, and Friedman et al, 1974). From about 1960, there has been a change in emphasis in the literature on the psychiatric sequelae of therapeutic abortion. These studies indicated that a negative reaction decreased over time and where guilt existed, it did not give rise to psychiatric illness or longlasting regret (Patt et al, 1969; Meyerowitz et al, 1971; Smith, 1973 and Green et al, 1976). In some instances, abortion is even seen as genuinely therapeutic (Forssman and Thuwe, 1966; Pare and Raven, 1970).

In studying the evolution of legislative provisions on abortion in various countries throughout the world, one finds that the issue is usually considered in the framework of penal legislation, which is often repressive. In time, with legal reform, legislation is enacted to provide for cases where the performance of abortion is not punishable, and in particular, where it can be justified on medical grounds, i.e. to safeguard the life or health of the woman. A later trend in some countries has been the introduction of specific provisions laying down the indications and the procedure to be

followed to obtain a legal abortion (see World Health Organization, 1971).

In South Africa under Roman Dutch law there was no legal provision for therapeutic abortion, although it was established in Common Law that a pregnancy could be terminated in order to save the life of the mother. In March 1972, the South African Medical and Dental Council issued the following guidelines, advising that abortion could be justified under the following circumstances:

1. To protect the life and health of the pregnant mother.
2. Where there was a real danger that an abnormal child would be born.
3. In instances of rape, incest or where the girl or woman was unable to understand the implications of coitus.

In 1973, the Abortion and Sterilization Bill was brought before the South African parliament. Psychiatric indications for therapeutic abortion were covered by Paragraph 3, Subsection 1:

> "where the continued pregnancy may endanger the life of the woman concerned, or may constitute a serious threat to her physical or mental health ..."

This Bill was subsequently modified, and in March 1975 the Abortion and Sterilization Act was passed. Paragraph 3, Subsection 1 included indications for termination of pregnancy on psychiatric grounds:

> "where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned .... and creates the danger of permanent danger to the woman's mental health and abortion is necessary to ensure the mental health of the woman."

Aims and Hypotheses of the Present Study

The aims of the present study were:

1. To study the implications of recommending or not recommending therapeutic abortion on psychiatric grounds for patients referred for such assessment over a 15 month period (1/2/74 - 31/5/75), working within the framework of the Abortion and Sterilization Bills of 1973 and 1974 and the Abortion and Sterilization Act 2/75.

2. To test the consistency of the decisions made with regard to therapeutic abortion during the period 1/3/74 - 31/5/74 under the Abortion and Sterilization Bill, with those made during the period 1/3/75 - 31/5/75 under the Abortion and Sterilization Act 2/75.

3. To describe the personal and social characteristics of all population groups presenting for psychiatric assessment for therapeutic abortion over the period 1/2/74 - 31/5/75.

4. To identify those characteristics which distinguished the patients in the group recommended for therapeutic abortion from those in the group not recommended for therapeutic abortion.

5. To isolate those factors in the psychosocial history which appear to have influenced the decisions made.

6. To conduct a follow-up study of both groups between 12 and 18 months after the patient's original presentation, in order to study the sequelae of the decision whether or not to terminate.

The hypotheses of the present study were:

1. Even if there are no data which can accurately

predict the risk to a woman's mental health of a continued pregnancy, nevertheless factors customarily considered 'psychiatric' influence the decisions made about its termination on psychiatric grounds.

2. Given a pregnancy which is thought to constitute a serious threat to the mental health of the mother, if measurable criteria cannot be specified before a decision is made by a psychiatrist, then factors other than those customarily considered 'psychiatric' are likely to influence the decision made, viz. psychosocial factors.
3. Attitudes to contraception and unwanted pregnancy on the part of the patient and/or her family contribute to a decision not to terminate a pregnancy on psychiatric grounds.
4. If therapeutic abortion is refused on psychiatric indications, then all patients will experience negative feelings to the continued pregnancy.
5. In the absence of psychiatric grounds for the termination of an unwanted pregnancy, little serious damage to the mental health of the patient ensues if termination is refused, as long as counselling and psychiatric services are available.

Method

Both psychiatric and social data were collected on 197 patients who presented for assessment for therapeutic abortion on psychiatric grounds over the period 1/2/74 - 31/5/75. All patients were referred from the Department of Obstetrics and Gynaecology of Groote Schuur Hospital to a special clinic run by the Department of Psychiatry. Patients were seen and assessed by one of two consultant psychiatrists and one of two psychiatric social workers in order to maintain consistency. A counselling service was also provided by one of

the two psychiatric social workers for both those recommended and those not recommended for therapeutic abortion.

Data was gathered on 157 patients (80%) of the original population 12 - 18 months after the decision whether or not to terminate. All patients were recontacted by the same psychiatric social worker. Data was also collected from other collateral sources. At the follow-up interview, women were asked to rate their emotional reactions on a 5 point rating scale, both as they felt at the time of follow-up and as they remembered having felt immediately after the abortion decision had been made.

All the initial and follow-up data of both those recommended and those not recommended for therapeutic abortion were examined for significant variables. The data was condensed into 2 X N contingency tables and chi-square tests were performed on these. The 5% level was accepted as significant. A discriminant analysis on all 159 variables was also undertaken.

Results

Of the 197 patients referred for assessment, 107 were recommended for therapeutic abortion and 90 were refused. Examining the data obtained at the original interview statistically, a few significant differences were found between the two groups. Taking the population as a whole and a modified sample, which omitted cases of rape and mental retardation, the following results were obtained. The variables weighting the termination group were 'referral for psychiatric treatment at the time of the interview', 'age' and 'parity'. Those variables weighting the non-termination group were 'previous sexual partner(s)' and 'ambivalence about the pregnancy and/or abortion'. The discriminant analysis showed that the three main factors that appeared to be significant in group allocation and, by inference, influenced the decision to terminate or not, were:

1. Referral for psychiatric treatment at the time of the interview.
2. Evidence of ambivalence over the pregnancy and/or abortion.
3. More than one sexual partner.

In short, hypotheses one, two and three were confirmed.

In comparing the decisions made during the two periods 1/3/74 - 31/5/74 and 1/3/75 - 31/5/75, minor differences were found between the two samples, but these did not appear to influence group allocation. Since none of the variables isolated in the discriminant analysis emerged as significant, it may be concluded that consistent decision making was maintained during the period 1/2/74 - 31/5/75.

Follow-up data was obtained from 104 patients personally, 22 by telephonic interview and 13 by letter. No information was available on 34 patients and collateral data from, for example, relatives, friends, general practitioner, outside agency, was collected on the remainder. 105 Patients completed the questionnaires rating their emotional reactions to the decision made. Those who had been terminated (77) experienced a greater sense of relief at follow-up than those who had not been terminated (28). Depression was found to be significantly different at follow-up as compared to reactions recalled retrospectively for both the termination and not termination groups. Results from a modified sample of 97 cases, omitting those pregnant as a result of rape, showed that all patients recommended for therapeutic abortion experienced greater immediate feelings of relief, happiness and least regret about the decision than those not recommended for therapeutic abortion. The latter reported more guilt and anxiety as immediate reactions, and long-term reactions included more doubt about the decision made and more regret about the whole affair.

At follow-up, of the 69 patients contacted in the group

not referred for termination, only 38 had gone through to term, the remainder reporting illegal, legal abortions elsewhere, or spontaneous abortions. Six of the babies born to the 38 women who went through to term were placed for adoption, 18 were born into two parent families and 14 into one parent families. Of these 38 women, four expressed persistently negative attitudes towards the continued pregnancy, 17 felt positively and 17 were ambivalent. These findings refute hypothesis number four.

To consider the mental health outcome at 12 to 18 months: fewer women in the non termination group reported having received or still receiving psychiatric treatment (7% by comparison with 14% for those terminated); fewer also reported having experienced adverse personality change (10% by comparison with 15%); and a small percentage (1%) being more socially isolated, by comparison with 7% in those terminated. These results confirm hypothesis number five.

Discussion and Conclusions

The fact that referral for psychiatric treatment at the time of the interview was found to be significant and was shown to be a weighting factor in the decision to terminate in the discriminant analysis, suggests that some decisions appear to have been based on evidence of psychiatric disturbance at the time of interview. Seventeen of the 107 patients recommended for termination were referred for psychiatric treatment. At later interview, one of these patients admitted that she had simulated psychiatric illness.

With age, parity and previous sexual partner(s) also being significant variables, it would appear that non-psychiatric criteria were also taken into account in the decision whether to terminate or not. Most patients under the age of 16 years and over the age of 30 years were recommended for termination. In the initial stages of this study, the Abortion and Sterilization Bill of 1973, which covered pregnant girls under the age of 16 years, was used

as a guideline, and almost all girls under the age of 16 years had their pregnancy terminated. The significant role of parity suggests that the long-term effect on the mental health of a multiparous mother rearing an unwanted child might be influencing decisions. More than one intimate relationship weighed against a decision to terminate. Possibly such a person was seen as irresponsible and even if granted termination on the grounds of personality difficulties, would soon fall pregnant again.

Ambivalence about the pregnancy and/or abortion weighed against a decision to terminate and emerged as one of the main factors assisting decision making from the discriminant analysis.

More negative reactions, such as regret about their situation, were experienced by those not recommended for termination, both initially and in the long run. Depression however, was found to be significantly less at follow-up for both groups, suggesting that such feelings fade with time. Since depression, guilt and anxiety were negligible in both groups at follow-up, it may be concluded that serious psychiatric sequelae do not appear to have resulted from either a decision to terminate or not to terminate.

Of the 38 women who went through to term, only four expressed persistently negative attitudes towards the continued pregnancy. Thus, of those women in the population examined who did go through to term, predominantly positive attitudes were eventually expressed towards the pregnancy.

Little serious damage to the mental health of the women in those not terminated was found at follow-up.

Once the variables of 'referral for psychiatric treatment as a result of the interview', 'ambivalence about the pregnancy and/or abortion' and 'more than one intimate relationship' were eliminated, the two groups seemed remarkably homogenous and it was difficult to extract which psychiatrically relevant variables had influenced the psychiatrist's

judgment in making a decision whether or not to terminate a pregnancy on psychiatric grounds. On the basis of the findings of this study, it appears virtually impossible to lay down any clear-cut guidelines that a psychiatrist can use to help in decision making. The question could be raised as to whether or not there are any purely psychiatric indications at all, especially as the simulation of psychiatric illness is not an unknown phenomenon.

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CHAPTER 1

HISTORICAL BACKGROUND

"Abortion has been practised since the beginning of organized society." (Babikian *in* Friedman et al, 1975, p.1496). Laws governing abortion have changed in the course of time and varied from country to country. However, in almost all cases, abortion laws were laid down in order to preserve the structure of a particular society. Only recently has the foetus been considered to have any rights in the abortion decision. The various attitudes towards abortion are, however, also closely tied up with the religious and moral attitudes of each individual. But only since the rise of Christianity has induced abortion become a serious concern of the state.

Some of the motivating factors for induced abortion in various societies from previous eras to the present time, may be illustrated through looking at primitive societies today. Devereux (1955) cites a number of determining factors which influence the decision to abort in primitive societies. These include:

(A) Medical and Biological Considerations

Including prophylactic abortions in those societies where a woman may abort due to fear of childbirth, e.g. the Puraris

(B) Political Causes.

(i) Dynastic factors, e.g. in order to safeguard the senior male branch of the royal house of Uganda from competition, princesses were not permitted to marry.

(ii) Absolutist excesses play a role in mass abortion.

(iii) Conquest, e.g. among the Toradja, slave women aborted because they did not wish to bear children who would also be slaves.

(iv) Miscegenation is closely related to conquest

and improper paternity.

(C) Social Structure.

(i) Improper paternity, e.g. father unknown, rape, incest.

(ii) Social pressure from a variety of sources may be put on the woman to abort, e.g. the girl's mother, lover, or medicine man.

(D) Economic Factors.

(i) A nomadic life discouraged women from having children too closely together since it was inadvisable to have more than one child who is not walking.

(ii) Economic factors, e.g. in New Britain it is considered improper to have children during the first two to four years of marriage.

(iii) Difficulties of child bearing - involves the economic factors of bearing children, as well as their socialization.

(iv) Unwelcome heirs.

(E) Family Dynamics.

(i) Illegitimacy.

(ii) Adultery.

(iii) Marital discord.

(iv) Protection of youthful beauty.

(v) Coitus taboos during pregnancy.

(vi) Dislike of the parental role.

(vii) Disappointed parents.

(viii) Housing.

(ix) Widowhood.

(x) Class-linked attitudes.

(F) Miscellaneous Customs and Attitudes.

(i) Cannibalism, e.g. some Central Australian women abort in order to feed the foetus to their starving children.

(ii) Abortion to demonstrate the technique.

(iii) Dreams and omens.

(iv) Religious reasons.

(v) Emotions motivating abortion, e.g. shame, fear and anger.

A number of these reactions appear to be consistently used as indicators for induced abortion.

Mention of the practice of abortion is found in the writings of the ancient Chinese, Hebrews, Egyptians, Greeks and Romans. The earliest abortifacient method in writing dates from 2737 - 2696 B.C. This method is found in the most ancient of medical records in the Chinese language. The earliest surviving record of the law and practice of abortion is found in the Middle Assyrian Code which was based on the Babylonian Code of Hammurabi, which was drawn up more than 3000 years ago. Among the articles is one which provides that if a woman has induced an abortion, she will be punished by impalement (Report of the Committee on the Working of the Abortion Act, Vol. 1, 1974, p.190). The religious books and records of the Hebrews, prior to the flight into Egypt, stress the importance of increasing tribal strength and no positive reference is found on abortion. This would countermand the command in Genesis to 'be fruitful and multiply' (Holy Bible Ch. 22). A further deterrent may have been the continuous warnings found in the Old Testament writings of the punishment of those who failed to keep Jehovah's commands. However, after the flight from Egypt, the Hebrews came under the influence of ancient Greek and Roman practices (Bates and Zawadzki, 1964).

The most learned of Greek and Roman gynaecologists, Soranos of Ephesus (C. 98-138 A.D.) noted three reasons for

obtaining an abortion: "to conceal the consequences of adultery; to maintain feminine beauty; to avoid danger to the mother when her uterus is too small to accommodate the full embryo" (Noonan, 1972, p.4). Plato, in his ideal state, felt abortion was appropriate where, at the time of conception the mother was older than 40 years and the father older than 55 years. Aristotle approved of abortion as a means of limiting the size of the population in the interests of the majority to maintain an economically sound community. However, he did so subject to the condition that the abortion should be obtained prior to the quickening of the foetus. The debate and distinction between the 'quickened' and 'unquickened' foetus was to remain a live issue until the present. The Hippocratic Oath is well-known with its pledge, "I will not give a fatal draught to anyone if I am asked, nor will I give a woman means to procure an abortion" (Hordern, 1971, p.17). However, abortion appears to have been generally practised in the Greco-Roman world, even though it was 'regarded as contrary to the social ethos (Report of the Committee on the Working of the Abortion Act, Vol. 1, 1974, p.192).

It was with the spread of Christianity that the first stand was taken against induced abortion. The pagan world had no moral objection to abortion; Christianity declared itself as opposed to paganism and all its practices. The early Christians took an absolute stand, particularly in matters relating to the family (Bates and Zawadzki, 1964). During the first century the offence of abortion was seen as an offence against God because it attacked what he had made. Infanticide was equally condemned, so that any distinction between formed and unformed foetus would not provide an escape (Noonan, 1972). However, the debate continued with regard to the difference between the 'quickened' and 'unquickened' foetus until 1869, when Pope Pius IX published a Bull in which he stated that the foetus possessed a soul as from conception (Report of the Committee on the Working of the Abortion Act, Vol. 1, 1974). The founding fathers of

the Church censored abortion as murder. However, although Tertullian condemned abortion, he justified embryotomy on grounds of necessity (Means in Hall, Vol. I, 1970).

Slowly Christianity emerged as a state religion and a social force in the Holy Roman Empire. During the fourth century, the attitudes expressed by earlier Christians took the form of legislation. The Council of Elvira was held in the West in C. 300 A.D. and the Synod of Ancyra in the East in 314 A.D. Both prescribed punishment of the woman who attempted to procure an abortion. In the West the punishment of excommunication was laid down, while in the East a penalty of ten years penance was prescribed. Neither of these laws made a distinction between the 'quickened' and 'unquickened' foetus.

In the fifth century, Augustine declared that the embryo before it was endowed with a soul, was 'informatus' and its destruction punishable by a fine only; the embryo 'formatus' was seen as endowed with a soul, as an animate being, and its destruction was therefore murder (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.194). While a number of church councils condemned abortion between the fifth and twelfth centuries, the distinction between the 'formed' and 'unformed' foetus had made its mark (Callahan, 1973). The Council of Worms, 868 A.D., condemned the destruction of a 'formed' foetus as infanticide. Excommunication continued to be the ordained penalty for the destruction of the 'quickened' foetus; it ceased to be so for the destruction of the 'unquickened' foetus within the Roman Catholic Church.

Canon law remained strict and at the Diet of Worms in 1521 A.D., it was declared that abortion and murder were synonymous. However, attempts were made to strike a balance between the life of the early conceptus and the life of the woman. The Jesuit Thomas Sanchez (1550 - 1610), argued that there were exceptions to the prohibition of abortion. "If the foetuswas not ensouled and the woman would die

without an abortion, then abortion was 'more probably' lawful, the foetus in this instance being an invader and attacker." (Callahan, 1973, p.412). Thomas Aquinas had held that ensoulment did not occur until the conceptus had a human shape and possessed basic human organs, since the human shape gave it its 'human' element. The human body was seen as the union of the soul with the undetermined prime matter (Llewellyn-Jones, 1974). The Council of Vienne in A.D. 1312 further codified this view by forbidding baptism of any birth which did not have a human shape. This was seen as occurring by the twelfth week of pregnancy (Llewellyn-Jones, 1974). Although in 1588 Pope Sextus V published a Bull in which he stated that the same penalties, canonical and secular, should apply to abortion as to homicide, regardless of the age of the foetus, a distinction was still held between the 'quickened' and the 'unquickened' foetus. In 1869 this distinction was reversed and ensoulment was held to take place at conception.

Initially, while the Church and State were still both one, the Roman Catholic approach to abortion was laid down in both secular and canonical law. However, after the Reformation and prior to 1803, English Common Law permitted abortion provided it was carried out before 'quickening', the point reached at about the sixteenth week of gestation. However, after 1803 abortion became an offence from the time of conception. In 1861 the Offences Against the Person Act was passed in the United Kingdom. This laid down that an abortion, whether successful or not, whether produced by the woman herself or another person, was a felony punishable by life imprisonment (Hordern, 1971).

In Britain in 1929 the Infant Life (Preservation) Act amended the law and provided for abortion if carried out in 'good faith' with the purpose of preserving the life of the mother. Historically the movement for legalized abortion began with the First World War. "Feminists proclaimed that women should have control over their bodies, psychiatrists warned of suicidal depression in young pregnant women, and

those who favoured social reform saw abortion as an end to the cycle of poverty" (Woods, 1975, p.78). The uncertain nature of the English law and its interpretation led, in the United Kingdom, to the formation of the Abortion Law Association in 1936. In 1938 Mr. Aleck Bourne, a London gynaecologist, openly performed an abortion at St. Mary's Hospital, Paddington, on a 14 year old girl pregnant as a result of rape (Hordern, 1971). Mr. Bourne was acquitted and the judge indicated that in certain circumstances a doctor had not only the right but the duty to terminate a pregnancy. In this case, preserving the life of the mother was interpreted as broadly as possible and included preserving the mother's mental health.

Looking back over the history of abortion, it may be seen how initially, abortion was sanctioned in order to maintain the equilibrium of a given society. This is still illustrated in the practice of abortion in primitive societies. Gradually social indications gave way to medical grounds, which then became acceptable. Thus, therapeutic abortions were performed when it was felt that the foetus aggravated an existing illness in the mother or threatened her life. With the advance of medical technology, medical indications have become limited to a small number of severe conditions, e.g. certain renal and cardiac complaints. At the same time, induced abortion became a safer procedure. Before 1940, indications were very largely medical, but after 1940 and the testing of the law by the Bourne case, psychiatric indications were included. By the 1950's psychiatric indications accounted for more than 50% of all abortions and by 1960, society was questioning the social, cultural, moral and ethical values related to abortion, and ultimately the question of the individual's right to freedom of choice.

The historical background of therapeutic abortion in the United Kingdom has been specifically cited as South Africa was at one time a British colony and the colonies invariably adopted the same legal approach as the mother country. However, this is not completely true of South Africa due to the

use of the Roman Dutch as opposed to English Common Law procedures.

Prior to 1973 when the Abortion and Sterilization draft Bill was brought before Parliament for its first reading, the legal position in South Africa with regard to therapeutic abortion was poorly defined. There was no legislation relating to abortion, with the exception of the Native Territories Penal Code of 1886. It had become accepted practice that where the practitioner performed a therapeutic abortion for bona fide medical reasons in order to safeguard the health of the pregnant woman, and after consultation with a senior colleague, the Attorney General of the province concerned would probably not prosecute the practitioner should it come to his attention (Geldenhuys in Oosthuizen et al, 1974).

The South African historical position may be traced back through Roman Dutch Law and Common Law authorities. Some of the earlier Roman Dutch authors regarded the distinction of a foetus as synonymous with infanticide. However, a distinction was made between the 'partus animus' and the 'partus inanimus'. Destruction of the former would be punishable in the same way as murder, but a much lesser punishment was meted out for the latter. Another guideline was taken from the criminalist, Matthaeus, who in 1644 wrote that should a choice have to be made between the death of the mother or destruction of the foetus, the second was the lesser of the two evils. Prior to 1973 the only legislation on abortion in South Africa was contained in four sections of the Native Territories Penal Code of 1886. Section 104 of this code states that the causing of the death of a live foetus is punishable, unless it is proved in good faith for the preservation of the life of the mother (Strauss, 1968). This law applied to Transkei, while the rest of South Africa fell under the provisions of Roman Dutch Law and Common Law.

From the above, it may be concluded that provision was made for therapeutic abortion on medical grounds. However,

no such coverage was given for the termination of pregnancy on psychiatric indications. In March 1972, the South African Medical and Dental Council laid down the following guidelines in abortion assessment. They considered that therapeutic abortion was ethically justifiable in order to protect the life and health of the pregnant woman, in cases where there was a real danger that an abnormal child was to be born, and in instances of rape, incest, or where the woman concerned was unable to understand the result of coitus. The following year, the Abortion and Sterilization Draft Bill of 1973 was brought before Parliament.

CHAPTER 2

ATTITUDINAL ASPECTS OF ABORTION

Religious Aspects

The great religions of the world have traditionally seen abortion as posing serious moral problems, though they have differed in their solution. Today, in nations as a whole, religion is nowhere a decisive factor in the practice of abortion, except to deter more liberal laws (Callahan, 1973). It has been shown that while the Church and State were one, therapeutic abortion laws directly reflected the values and attitudes of the Church, although illegal abortion was ever present. With the Reformation came the possibility of a wider split between Church and State. However, although the Church can no longer directly introduce legislation, it does have a powerful effect on the legislation of governments of countries where one particular religion predominates. Thus in Portugal and Spain, where Roman Catholicism is the state religion, abortion is prohibited. The historical background, religious aspects and moral and ethical attitudes towards therapeutic abortion are all closely related and are given expression in the abortion legislation of a particular country. Not only is religion important in affecting the abortion legislation of a country, but it is also equally important in the view of each individual towards abortion, and of the individual's immediate group. Thus, in the counselling of a particular woman who is seeking an abortion, her religious views should not be overlooked and should be given due respect. A counsellor needs to have knowledge of the various religious views, especially in a country such as South Africa where different ethnic groups who may have different religions, live side by side. A resumé of the attitudes of the various religions in South Africa towards therapeutic abortion is presented.

Islam

The Islamic creed as set down by Mahomet, was derived

from both Judaism and Christianity, but has distinct laws of its own. Islamic jurists permit abortion under certain conditions. The abortion must be carried out within the first 16 weeks of gestation, as the foetus at this stage is not accepted as falling within the definition of human life. It is considered that there is no harm in abortion provided that the foetus has not taken human shape (Nadvi in Oosthuizen et al, 1974). Mutual consent of husband and wife is necessary. In cases of direct threat to the life of the mother, no consent is necessary and abortion may be performed after the 16th week of pregnancy.

Hindu

Abortion is totally opposed by the Hindu religion with its emphasis on transmigration of souls and the sacred nature of marriage and sex. "The main aim of marriage is to guide natural desires out of their promiscuous tendencies and to allow them to express themselves in a monogamous relationship" (Bhoola in Oosthuizen et al, 1974, p.51). This is emphasized by a number of sacraments which are performed during pregnancy in order to ensure a safe embryonic period and safe delivery of the child.

Buddhism

All life, animal and human, is held sacred by the Buddhist religion. Abortion is contrary to such a religious belief. However, Buddhism is aware of man's weaknesses and tries to consider both the welfare of the family and community, as well as that of the individual. As such, abortion is permitted tacitly and definitely where the life of the mother is in question.

Judaism

The basic ethical code which is the basis of the Jewish faith is crystalized in the Ten Commandments. As such, the conclusion could be drawn that abortion is breaking the commandment "Thou shalt not kill". However, this is determined by the different definitions of the foetus, of

viability and of ensoulment as held by the various sects. Many of the greatest Jewish scholars considered abortion "as a legitimate legal exercise of parental privilege in certain circumstances" (Margolis in Hall, Vol. 1, 1970, p.30). This is borne out by recourse to the Old Testament. Exodus 21 : 21-23 starts, "And if men strive together, and hurt a woman with child, so that her fruit depart, and yet no harm follow, he shall surely be fined, according to the punishment the woman's husband shall lay upon him; and he shall pay as the judges determine. But if any harm follow, then thou shalt take life for life." The implication here is that destruction of the foetus was equivalent to damaging property, not to murder. It was seen as part of the mother, and damages had therefore to be paid. However, if the mother should die, then it became a capital offence. This has remained as the Talmudic tradition up to the present.

Prior to birth the foetus is seen as part of the mother and has neither individual life nor personality of its own (Llewellyn-Jones, 1974). Neither does it possess a soul. Rabbi Solomon of Skola summarizes the modern Jewish view of abortion as being "that there can be no objection to abortion performed within the first 40 days after conception, and it may be done later if the life or health of the mother is endangered" (Llewellyn-Jones, 1974).

Christianity

To discuss the Christian attitude towards abortion, it is necessary to separate those views held by the Roman Catholic Church and those of the Protestant Churches. Chapter 1 covered the attitudes of Christianity as expressed until the middle of the last century, from where it is picked up here.

(a) Roman Catholicism

From the mid-nineteenth century, the papal trend has been towards an increasingly more stringent prohibition of abortion. In 1869 Pope Pius IX in the Constitution 'Apostolicae Sedis' caused a sharp change in the law by eliminating any

distinction between the 'quickened' and 'unquickened' foetus. Ensoulment was held to take place at conception and excommunication was the punishment meted out both to the woman having an abortion and to the person who performed it.

During this century a series of strong papal statements have been made and continue to the present. Pope Pius XI in his encyclical 'Casti Connubii' (1930) strongly condemned abortion at all times, even when the life of the mother was directly threatened. He alluded strongly to the commandment "Thou shalt not kill" and described abortion as the direct killing of the innocent (Callahan, 1973). In 1951 Pope Pius XII emphasized that the child in its mother's womb received its life directly from God, not from its parents or society. Pope John XXIII in 'Mater et Magistra' (1961) wrote that from its inception, human life was sacred and the result of a divine action from God. By violating this divine act, God is offended and the individuals themselves, as well as humanity, are degraded (Callahan, 1973). After the Second Vatican Council, Pope Paul VI in his encyclical on birth control, 'Humanae Vitae' (1968), once again condemned abortion even for therapeutic reasons.

It is important to note, however, that there are two exceptions in which abortion is condoned by the Roman Catholic Church. Abortion in both of these instances is the indirect result of legitimate medical practice. These are the treatment of an ectopic pregnancy and a cancerous uterus (Callahan, 1973).

Callahan (1973, p.417) sums up the Roman Catholic stand on therapeutic abortion as follows:

1. "God alone is the Lord of life.
2. Human beings do not have the right to take the lives of other (innocent) human beings.
3. Human life begins at the moment of conception.
4. Abortion, at whatever the stage of development of the conceptus, is the taking of innocent human life."

The conclusion to this is that abortion is wrong. This fact leads to concern among some Roman Catholics, both clergy and laity, that such an absolute stand is continuing to conflict with prevailing social attitudes. This approach is being more and more influenced by a humanistic outlook, lacking a theological base.

(b) Protestantism

It is impossible to discuss the stand taken by the Protestant Churches in the same manner as may be done with the Roman Catholic Church. The Protestant Churches are inconsistent in their opinion and are pluralistic, each being unique to itself. At the same time, there is a general feeling that in most instances the Protestant Churches have not taken any dogmatic stand and the individual is left to formulate his own approach to the problem.

Theoretically the Protestant Churches are all firm in their stand on the principle of the inviolability of the foetus and that its rights must be guarded. However, this is not taken as an absolute stand as it is in Roman Catholicism and other rights are allowed to be taken into consideration, e.g. the mental and physical health of the mother. This deviation from the absolute has led to very unclear boundaries in the Protestant approach to abortion, even though the Protestant Churches have adopted the values of the worth of human personality and the sanctity of life from the Roman Catholic faith.

There are three Protestant positions which appear to be present in all of the denominations:

1. The embryo is seen as having its own autonomy and is thus a developing 'humanitus' which is as sacred as any human life. But even in this approach, abortion may be used for therapeutic reasons which are considered 'lesser evils'.

2. The most frequently voiced opinion is that

which allows for abortion when the mother's health, physical or mental, is threatened.

3. The other extreme sees the mother's full value and worth as including the right to decide for or against abortion (Ellis _in_ Oosthuizen, 1974).

In 1961 the National Council of Churches in America approved of induced abortion for the sake of the mother's health, and in 1962 the British Council of Churches decided that biological life became human life at the time of and not at conception.

In 1974 Oosthuizen (_in_ Oosthuizen et al, 1974, p.64) cited four instances where the Dutch Reformed Church of South Africa condones therapeutic abortion:

1. "Where the life of the mother is threatened as a result of continued pregnancy, or where her physical health will be impaired seriously and permanently; where continued pregnancy in all probability will lead to the development of a physical disturbance with a woman or when it will aggravate such a disturbance so that it becomes a threat to her own life and/or to that of the child, or that she will experience a permanent serious physical maldevelopment;
2. where rape or unlawful conception is proved to have taken place outside the domain of love and without consent and is seen as violation of the body as the temple of God's spirit;
3. where incest is accompanied by rape, or where mental deficiency is prevalent in the man and/or the woman;
4. where the pregnant woman is physically so disturbed that she does not understand the sense and meaning, and thus also neither the consequences, of intercourse."

The Dutch Reformed Church does not accept social, socio-economic or eugenic indications as grounds for therapeutic abortion.

That the consensus of lay Protestant opinion favours a more liberal attitude to legally induced abortion for social as well as medical indications, is demonstrated by the changes in legislation in predominantly Protestant as opposed to Roman Catholic countries.

Ethical Considerations of Therapeutic Abortion

The ethics of abortion are concerned with the moral aspects of the abortion decision. These moral values are closely linked to religious beliefs and are further expressed in legislation. There are a number of ethical issues to be considered in the abortion decision which are highly relevant to the legal, medical and social aspects of abortion.

Joseph Fletcher (1971, p.1124) states that "the right question is not whether termination of a pregnancy is ever justifiable, but whether compulsory pregnancy is ever justifiable." He goes on to isolate five basic problems (1971, p.1125). Firstly, in law, the question is whether anybody should be compelled against her will to bear a child. Secondly in jurisprudence, the question is whether or not abortion is a form of homicide and if so, why? Thirdly, in theology the question is whether God has a monopoly on the control of life, giving nature an overriding priority over human initiative and responsibility. Fourthly, in metaphysics, is foetal life or embryonic life human life, and if so, when and why? Ethically the question is whether abortion is intrinsically and inherently wrong and if not, when is it right?

The various opinions with regard to whether abortion is acceptable or not have been discussed with reference to the various religious codes. Other ethical issues include the question of when life begins, the sanctity of life, the rights of the mother and those of the foetus, confidentiality and consent needed prior to the abortion decision.

When Does Life Begin?

Life is a continuous process from the fertilization of the ovum to the death of the individual. The question posed is at what point on this continuum does 'life' become 'human life'? At fertilization one sperm cell unites with a viable egg. This fertilized egg is referred to as the zygote and combines both maternal and paternal genetic material. A continuous process of cell division takes place after fertilization and after six or seven days, this cluster of cells, called the blastocyst, arrives in the uterus from the fallopian tubes. Nidation occurs when the blastocyst is implanted in the uterus wall. From the eighth week of gestation this fertilized ovum, which has implanted itself in the uterine wall, is called a foetus. Continual cell division and differentiation occurs up until approximately the 266th day after fertilization when the infant is delivered. Looking at this continuum, life may be seen as being present throughout, or as coming at particular stages, e.g. at fertilization, nidation, 'quickening', etc.

The discussion of the question of when life begins runs parallel with the religious question of when ensoulment takes place. Initial Christian objection to abortion was grounded in this speculation about the soul (Smith, 1970). Three different theories about the origin of the soul and its union with the human body have been held in Western Christendom (Smith, 1970, p.27):

1. Tertullian held that the soul came into existence with the body as a biological transmission from Adam through one's immediate parents.
2. Clement of Alexandria held that the soul was immediately and directly created by God.
3. No soul is present in foetal life until the moment of 'quickening'.

It was not until the 17th and 18th centuries that Roman Catholic doctrine on ensoulment and the inviolability of foetal

life began to take a specific stand on abortion and ensoulment, a stand which is present until today.

Smith (1970, p.34) comments on the rigorous stand taken by the Roman Catholic Church and states that "such rigorism in ethics, extrapolated from a certain kind of law theory, both depersonalizes and dehumanizes the decision making process, and finally subordinates man's capacity (however limited) for self-determination and purpose to the erratic and sometimes capricious, but always impersonal forces of his natural environment."

Bonhoeffer (Smith, 1970, p.38) in his paper 'Reproduction and Nascent Life', argues that firstly, the embryo's existence is itself evidence of God's intention to create a human being, secondly, that the embryo's right to life is therefore divinely bestowed, and thirdly, that any deliberate deprivation of it is 'nothing but murder'. This attitude runs parallel to that of the Roman Catholic Church. However, biologically this is not considered completely sound. If ensoulment is taken as occurring at fertilization, what happens in the case of identical twins when a single ovum divides after fertilization and prior to nidation?

At the other end of the spectrum of the argument as to the beginning of human life, Joshua Lederberg (Engelhardt, 1973) takes a very radical viewpoint. He argues that the beginning of human life really takes place when the child begins to interact meaningfully with his environment, with the acquisition of language, and with continued intellectual development. He feels that it is only at about the first year of life that the infant enters the cultural tradition which separates man from other species, and thus becomes a 'human being'. If this radical approach were adopted, it would require the destruction of numerous individuals. Engelhardt (1973) argues that even though an infant does not immediately assume a full personal life, from the moment of birth the infant plays an explicit role within the social structure of the family. Even though the infant is not

rational, he may elicit rational responses in others. Engelhardt (1973) states that human life is an unbroken continuum extending from person to person. As such, he attempts to identify a point on this continuum where the quantitative changes of the foetus become qualitative changes of a developing infant. He attempts to resolve this issue by identifying viability as such a point. Viability is the point at which a foetus, if removed from the uterus either through premature birth or deliberate delivery, is considered to be capable of possible separate existence. This is usually taken to be from about the 28th week of gestation. However, with medical advances this time is gradually being pushed back. Engelhardt (1973, p.33) states that "the criterion of viability is a cardinal criterion for understanding the place of man in medicine, in particular for understanding where in his ontogeny man first emerges for medicine."

John Fletcher (1975) picks up the argument of the accessability of the foetus or infant to medicine as a criterion for defining the term 'human being'. He isolates three points in distinguishing between an infant and a foetus (p.76):

1. The separate physical existence of the infant, apart from the mother, confronts parents, physicians and legal institutions with independent moral claims for care and support.
2. After birth, disease in the infant is more available to physicians for palliation or perhaps even cure.
3. Parental acceptance of the infant as a real person is much more developed at birth than in the earlier stages of pregnancy.

With all these differing opinions on the beginning of life, there is still the question of what constitutes 'human life'. Joseph Fletcher (1971, p.1125) states that "there are a number of psychologic, religious and culturally conditioned causes for 'believing' that foetal life is human life, but such a belief is a psychologic phenomenon, not a

social or scientific or rational conclusion." He further states that "there is no such thing as embryonic 'human life', medically speaking, and those who choose to 'believe' this are exercising their religious liberty, but to do so is a matter of personal faith." (p.1126). He sees existing laws as imposing on our pluralistic society an inherited archaic Christian metaphysics of man. He feels that prior to birth the embryo is merely part of the mother which may be removed if it is detrimental to her health. He rejects the idea of ensoulment or any one point on the continuum of the foetus's life as a specific cut-off point for abortion.

From the above may be seen the confusion and diverse opinions surrounding the term 'human being', especially in relation to therapeutic abortion. The ranges of opinion cover, at one end, those who believe that human life is sacred and starts at the point of fertilization of the ovum, while at the other end, there are those who see human life as emerging when the infant begins to interact meaningfully and purposefully with his environment. In terms of therapeutic abortion, the upper limit of 28 weeks may be taken as the point of viability. Therapeutic abortions up to this point, are sanctioned in certain areas of the world. This was the upper limit stated in the British Abortion Act of 1967. However, due to medical advances, in 1974 the Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974) recommended an upper limit of 24 weeks gestation. In South Africa no such limit is mentioned in the Abortion and Sterilization Act 2/75, although in practice abortions are seldom performed after the 24th week of gestation unless the mother's life is directly in danger.

The Preservation of Life

The debate on the rights of therapeutic abortion has as its central issue the preservation of life, or as theologians would say, the sanctity of life. All the arguments and indications specified either by law or religion, bring to mind such questions as: Should maternal life be preserved

at the expense of that of the foetus or visa versa? Are all lives of the human species not equal? If they are, why do many abortion laws throughout the world lay down indications for the therapeutic abortion of mothers who may be carrying a mentally or physically defective foetus? Do such laws imply that some lives are worth more than others or have a certain priority? The spectrum of opinion of therapeutic abortion ranges from those who see it as the abandonment of respect for life to those who see it as a positive form of birth and population control.

The decision taken by those counselling a woman requesting therapeutic abortion and how they interpret the indications and the legislation, is considerably affected by their own moral evaluation of abortion. Callahan (1973, p.327) emphasizes the need for consistency in the ethical aspects of abortion and cites five rules relating to the sanctity of life:

1. "The survival and integrity of the species.
2. The integrity of family lineages.
3. The integrity of bodily life.
4. The integrity of personal choice and self-determination, mental and emotional individuality.
5. The integrity of personal bodily individuality."

All of these areas have been affected by the impact of modern medical, scientific, technological and social change. With these changes the scope of moral decisions has increased and the traditional principles of the preservation of life have come into question. This is illustrated as much in the debate on euthanasia as on that on therapeutic abortion.

The concept of the sanctity of life originates from the idea of life being derived directly from God. It is a gift from God, it is therefore sacred and should, therefore, not be abused. Since life is a grace of God, it should be respected and treated with dignity. This refers as much to

one's own life as to that of others. Abortion is seen by some to be the abandonment of such respect.

The Roman Catholic Church has continued to reaffirm the sanctity of life and in terms of therapeutic abortion, has taken a firm, negative approach. However, two lives are involved in the therapeutic abortion issue. It is interesting to note that in certain cases the Roman Catholic Church affirms this. Direct abortion is always prohibited on the ground that maternal and foetal life are equal, and therefore neither may licitly be preferred to the other. However, indirect abortion is permissible if four specific conditions are fulfilled (Smith, 1970, p.31). Firstly, the action considered by itself and independently of its effects, must not be morally evil; secondly, the evil effect must not be the means of producing the good effect; thirdly, the evil effect is merely tolerated and sincerely unintended, and fourthly, there must be a proportionate reason for performing the action despite its evil consequences. Indirect abortion is considered to fulfil these criteria. Only in this instance does the mother's life come before that of the foetus. Two such medical conditions are accepted - ectopic pregnancy and cancer of the uterus.

A continued respect for life is illustrated by the legislative measures taken in various countries to define the indications for therapeutic abortion. However, conflicts arise between the rights of the woman and the rights of the foetus. This confusion is seen in the various world legislative measures - from complete prohibition to abortion on demand.

It is felt by some that the preservation of the species is directly affected where liberal abortion laws exist. Louisell and Noonan (in Noonan, 1972) argue that easy abortion would present a reversal of the law's progress toward recognition of the dignity and essential equality of human life. They feel that it is a retrogressive step in man's development and that attempts to justify it on the ground that a foetus is not fully human are not logical since

conception marks the start of human life and any other reference point should be arbitrary.

Therapeutic abortion may be seen as a threat by some to human existence, e.g. 'Black-genocide' in New York, where abortion is completely on demand. It may be seen as the abandonment of respect for human life and dignity and as a mortal sin. Pro-abortionists see it as a logical and legitimate extention of contraception, as a positive measure of population control and the ultimate right of the woman to have control of her own body.

The Rights of the Mother and the Rights of the Foetus

As stated earlier, Joseph Fletcher (1971, p.1125) poses the question, not as to whether therapeutic abortion is ever justifiable, but whether 'compulsory pregnancy' is ever justifiable. Historically, the movement for legalized abortion began after the First World War, but danger to life or health were the only grounds for therapeutic abortion until more liberal legislation was passed in the various countries in the late 1960's and early 1970's. The question has now become one of the inherent right of the woman to decide whether she does or does not wish to continue with a pregnancy. By some it is seen as a struggle between the two sexes, where men make the legislation which women have to accept. Israel (1971, p.1115) states that "the basic dichotomy between the two sexes has been exploited to support political, economic and sexual male supremacy." Although women have been emancipated to a large extent during this century, the undeniable fact remains that the various life roles played by women, which are mainly biologically derived, continue to produce inequality between the sexes. Confusion and conflict are produced as a result of the basically innate femaleness of the woman and her socially competitive role, which demands more masculinity. Many feel that therapeutic abortion should be a matter between the woman herself and her physician and no one else. Smith (1970, p.26) states: "There is much, of course, that is at stake in

consideration of abortion; but the women's right in a free society, to make the ultimate decision - however much informed by medical, moral and other opinions - surely should be among the highest priorities and deserves safeguarding." The principles of self-determination and the right to have control over one's own bodily functions should not be overridden by conservative abortion legislation.

It is equally important to examine the concept of abortion on demand, which may also be seen as not being the ultimate solution to the debate. The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974) makes a clear distinction between abortion on demand and abortion on request. In the former case, the woman may pursue her right to have an abortion regardless of professional opinion. In the case of abortion on request, the woman would not have to 'prove' that she has grounds for a therapeutic abortion, but the abortion would be subject to professional approval and willingness to perform the operation.

Gardner (1972a) points out three difficulties arising from the standpoint of abortion on demand. Firstly, it implies that conceiving and childbearing are two separate and almost unrelated events. He feels that this runs contrary to the female psychology. Secondly, the woman does not know what is involved in a decision of this nature. She cannot know if there will be any operative complications, whether she will conceive again, how her own conscience will react post-operatively nor how other family members will react. Thirdly, the woman in this situation finds herself having to make a major decision when she is least able to do so and may wish only to 'wipe out' the reality of the present. It is therefore evident that counselling of some sort is appropriate prior to the abortion decision, but the woman involved should not be swayed by the views of either her own family or of the physician. At this point, she needs help in making her own decision to abort or not.

The anti-abortion lobby supports the rights of the foetus to attain human existence and argues that it is

incongruous that the foetus should have a certain status in other laws, but would have to forego this status in abortion laws if abortion on demand were introduced. In ancient law the relationship between maternal trauma and miscarriage was recognized. Hammurabi laid down that damages should be paid by an assailant who struck the daughter of a patrician, plebian or slave girl, causing her to miscarry (Gordon, 1965a). Today the foetus has certain rights in property law, criminal law and tort law in Anglo-American legislation. The foetus has the right to inheritance of property. In criminal and common law, the rights of the foetus are protected by the abortion laws, which indicate the grounds for therapeutic abortion and state where and by whom the operation may be performed. The law of torts recognizes the right of the foetus to sue for damages if harmed, and also recognizes the civil rights of the unborn child, e.g. an unborn child has been held to be a 'child' or 'other person', allowing him to bring an action for the death of his father where the death occurred prior to the child's birth (Louisell and Noonan <u>in</u> Noonan, 1972).

One possible compromise of the dilemma between the rights of the mother and the rights of the foetus, is to have legislation specifically protecting the foetus only after a certain period of gestation (Sarvis and Rodman, 1973). It may be seen that abortion laws do attempt to protect the woman from having an abortion in unlicensed surroundings, by unlicensed practitioners and criminal abortionists, and they attempt to protect the foetus by laying down specific indications for therapeutic abortion and by defining the upper limits of gestation.

Admission of the rights of the foetus to life leads to the question of what kind of life the child will have. Ideally, a child should be born into a home where he or she was conceived in an atmosphere of love, and where he or she is specifically wanted. This is the foundation of the ideal family unit. The question also arises of the abortion of the abnormal foetus and the right of the child to be born

physically and mentally 'normal'. Preventive psychiatry and the quality of life are discussed in Chapter 4, as are the results of children born after therapeutic abortion has been refused.

Against this delicate background of weighing the rights of the foetus and the rights of the mother, therapeutic abortions are gained according to the legislative measures of any given country. It is interesting to note that in the literature the rights of the reputed father are seldom discussed or considered.

✓ Consent and Confidentiality

Consent and confidentiality are two further aspects of the abortion decision which may place the counsellor in a moral dilemma. In Britain, girls between the ages of 16 years and 18 years are no longer required to get parental consent. This provision was made in the Family Law Reform Act of 1970. In girls under the age of 16 years, written consent from the parent or guardian is required. However, wherever possible discussion with parents is urged, although parental attitudes should not affect the decision to abort or not to abort. Written consent is required from the woman concerned and wherever possible the views of the husband should be obtained, although this cannot affect an abortion to save the life of the woman. Emergency operations should not require such consent. The consent of a common law husband or the man responsible for the pregnancy is not required. In South Africa, written consent is required of the patient and wherever possible, that of the husband. The latter is obligatory for women married in community of property. Written consent is also required of the parents of a woman under the age of 21 years.

Confidentiality between the patient and the counsellor cannot be guaranteed - there are other people officiating at the operation, other patients in the ward where the woman may be placed, also she is urged to discuss the matter with her husband and/or parents. The abortion may only be

performed after the official channels have been put into motion. In Britain, the woman is required to have the consent of two medical practitioners and the operation must be reported to the Chief Medical Officer of the Ministry of Health within 7 days. In South Africa, in terms of Paragraphs 4 and 6 of the Abortion and Sterilization Act 2/75, similar regulations exist, with two medical practitioners giving their opinion, plus countersigning by the medical superintendent of the hospital where the abortion is to take place before the operation. A report must be sent to the Minister of Health within 21 days of the operation. With all these procedures, the patient may well feel that her anonymity cannot be maintained. This is particularly so in South Africa where all therapeutic abortions must be performed in a state or provincial hospital, and no access to either private hospitals or private professionals is allowed. In some countries where the abortion laws are fairly liberal, but where criminal abortions are still reported, it has been postulated that some women prefer to have a criminal abortion and maintain their confidentiality rather than to conform to the bureaucratic structure of the abortion laws.

Attitudes Towards Therapeutic Abortion

Opinion surveys are relevant when attempts are made to introduce social or legal reforms. The opinions of both the general public and the professionals concerned are of importance. As stated previously, attitudes towards abortion are affected to a large extent by the individual's religious beliefs. Discussion here is concerned with both the attitudes of the professionals concerned and general public opinion.

The three main professionals concerned with the abortion decision are the gynaecologist, the psychiatrist and the general practitioner. However, in order to produce an efficient and humane abortion service, it is important to take into consideration the feelings of other personnel who may play a part in the abortion procedure, e.g. the nurse, social worker, anaesthetist. Staff attitudes and feelings

directly affect the work involved.

Gardner (1972a, p.50) states that many antagonists of the abortion law reform make great play out of the Hippocratic Oath dating from the fourth century B.C., which contains commitments to "share one's substance with one's teachers, to teach the art to one's sons and teachers' sons" and vow that "neither will I give a woman means to procure an abortion" (Hordern, 1971, p.17). The doctor is the traditional maintainer of life. He may find himself being asked to terminate a life for little more than the inconvenience of the mother. Resentment may exist towards the demands of people who are either not seen as being ill or who are regarded as being thoughtless or immoral. It is important for the staff concerned to be aware of how they feel towards each case, and they should therefore be aware of the facts of each case. For the nurse, it is a particularly difficult part of her work. Like the medical practitioner, she has been trained in the tradition of maintaining and not destroying life. She may find herself in a mixed gynaecological ward where she is required to give sympathy to the woman who has lost a baby and acceptance to the patient who has had an abortion.

Hordern (1971) points out that before the passing of the British Abortion Act of 1967, the majority of gynaecologists were opposed to terminating pregnancies, especially on psychiatric grounds, since the operation ran counter to their training and philosophy, contravened accepted medical ethics, and was of uncertain legality. Some objected on religious grounds, but most were wary of the legality of therapeutic abortion. In accordance with a general attitude of conservatism, the Report of the Council of the Royal College of Obstetricians and Gynaecologists in March 1966 took a relatively firm stand. The report noted the general world trend of liberalizing abortion laws in order to reduce criminal abortion, but noted that in many cases this led to recurrent demands for abortion rather than responsible use of other forms of contraception. The report also pointed out that while continuation of the pregnancy may have

psychological side effects, so might abortion. It emphasized that the person performing the operation "should clearly satisfy himself that the risk of allowing the pregnancy to continue was for that particular woman greater than the risk of terminating it" (Hordern, 1971, p.19).

The psychiatrist holds a unique position in the abortion decision. He is not involved in the actual operation and may, due to this, be more able to make an objective decision. He also spends much longer with the patient and is able to explore the possible wider effects of terminating or not terminating a pregnancy in a given woman. These factors tended to make the psychiatrist favour therapeutic abortion of unwanted pregnancies (Hordern, 1971). In accordance with this, the 'Memorandum on Therapeutic Abortion' published in Britain in 1966 by the Royal Medico-Psychological Association, took a liberal view. It stated that clarity in the British law was needed and a broader term of reference for indications for therapeutic abortion, since the available knowledge showed that abortion contributed to the promotion of health.

Hordern (1971) discusses that prior to the British Abortion Act of 1967, the general practitioner was closer to the psychiatrist than to the gynaecologist in his stand over therapeutic abortion. Like the psychiatrist, he seldom takes part in the operation, but holds a unique position as family doctor and is able to see at first hand the possible outcome of unwanted pregnancy.

With the passing of the British Abortion Act in 1967, altered attitudes of the personnel concerned were noted (Hordern, 1971). The majority of gynaecologists came to view therapeutic abortion on psychiatric grounds as being justified in many instances, and their fear of the physical complications lessened with the perfection of the techniques used in the abortion operation. However, as the number of patients gaining abortion on psychiatric indications increased over the last decade, psychiatrists began to feel that psychiatry was being exploited, and that the operation

should be a matter between the woman and her gynaecologist (Babikian in Friedman et al 1975). General practitioners did not appear to have changed their attitude, but had it generally reinforced by the effects of liberalized abortion laws.

Abortion laws have become increasingly more liberalized throughout the world, and the attitude that it is a woman's right is evident. Because of the delicate moral and ethical issues involved and the highly emotional debate on the creation and destruction of life, it is important to have built into abortion laws a clause for conscientious objectors, which would free such professionals from the burden of such operations and prevent their negative feelings from being transmitted to the patient. In the British Abortion Act of 1967 a conscientious objectors clause exists and frees the individual from the responsibility of decision-making and performing the operation, but protects the woman's rights by insisting that she be re-referred to a doctor willing to assess her for therapeutic abortion. The South African Abortion and Sterilization Act 2/75 also allows for non-participation of conscientious objectors, but does not mention re-referral to protect the woman's rights.

For most women abortion is an emotionally traumatic experience. Many approach it with feelings of guilt and anxiety and fear of possible negative reactions of others. The nurse plays a vital role in reassuring the woman and is able to do so due to close contact with the patient. Thus, the nurse with negative or ambivalent feelings towards these patients and towards her own role in this aspect of nursing, can do harm by increasing existing guilt feelings and producing conflicts in the patient, which may persist after the operation. The nurse, in the course of training, has learnt the value of life. She has participated in the creation of life in labour and delivery, the preservation of life in the care of medical and surgical patients, and in the prolonging of life in geriatric patients. The abortion patient represents the converse of these values - the taking

of life.

Char and McDermott (1972) studied the reaction to abortion of a number of nurses with acute anxiety reactions to the procedure. Group sessions with these nurses were found to be of value in allowing the nurses to discuss their feelings. From these discussions, acute psychological reactions to abortion work were uncovered. The following were isolated as common reactions:

1. "All suffered from strong emotional reactions to their abortion work and welcomed the opportunity to talk about them.
2. Many overidentified with the aborted foetus.
3. The nurses felt hostile towards most of the abortion patients.
4. The nurses suffered from an acute identity crisis regarding their nursing role and function." (p172, p.67-68).

Kane et al (1973a) studied the emotional reactions of the various abortion services' personnel. They found that the staff reported "occasional depression, anxiety and much obsessive ruminative thinking regarding their involvement with the performance of large numbers of abortions" (p.409). Involvement of the doctor was unconsciously restricted to the most limited required. Nursing personnel felt this lack of leadership and also suffered through trying to solve their own ambivalent feelings towards the procedure. These were particularly noted when the hypertonic saline procedure was used. Invariably the nurse was the only person present when the patient aborted. She was also confronted with her ambivalence in nursing both abortion patients and other obstetric and gynaecologic patients in the same ward.

Kane et al (1973, p.411a) made a number of recommendations for abortion programs as a result of their study of the personnel involved. These include:

1. "If at all possible, participation in these programs should be on a voluntary basis for all concerned.
2. The program should have strong medical leadership, preferably by someone whose feelings are strongly positive to the program.
3. It would be desirable, if at all possible, to have these patients apart from obstetric patients and served by a separate staff.
4. Another positive step would be to cut down outside referrals and deal with patients from one's own catchment area, thereby enhancing the patient-doctor rapport and opportunity for follow-up for assessment of long-term response.
5. Physician presence to support nursing procedure seems badly needed in the termination phase of the saline procedure.
6. There is a need for the development of training programs equipped to deal with the problems generated by the abortion programs."

Mascowich et al (1973) studied the attitudes of obstetric and gynaecologic residents in California towards abortion and found that although there is recognition and acceptance by most residents of the social need for therapeutic abortion, considerable ambivalence still persists. The authors felt that a distinction is required between the negative feelings about the taking of human life, and the negative feelings about sexual activities of the woman receiving abortion.

Attitudes of the general public towards abortion are important as these attitudes ultimately affect abortion legislation. Prior to the Second World War, attitudes were relatively conservative and conformist. In 1929 the British Parliament passed the Infant Life Preservation Act,

which exempted a physician from being prosecuted if an abortion was performed to save the life of the mother. The Roman Catholic attitude was to take a firm stand and it did not condone this indication for therapeutic abortion. It has continued to uphold the principle of the sanctity of life until the present day. The Protestant Churches have traditionally differed from the Roman Catholic Church in placing the onus of responsibility of one's own actions on the individual. In 1965 the Committee of the Church Assembly Board favoured therapeutic abortion where it was adequately justified, i.e. to save the life or health of the mother. But it also stated that it felt abortion should be forbidden for three reasons:

1. "The right to life of the foetus.
2. The interest of society in its own survival.
3. The possibility that there would be weakening of reverence in the trivialization of the sexual act" (Hordern, 1971, p.14).

Public opinion is largely influenced by religious beliefs. However, a general liberalization of public opinion has developed over the past decade, although ambivalence in the taking of life is still very evident. The Royal College of Obstetricians and Cynaecologists in their report on 'Unplanned Pregnancy' (1972, p.38) state that "among married women, particularly in the lower socio-economic group and those of high parity, there has always been a considerable and a greater readiness to resort to illegal or self-induced abortion."

In South Africa, Market Research Africa conducted an opinion poll in July 1975. The survey covered 'European' adults aged 16 years and over, living in cities, towns and villages throughout South Africa and was representative of 86% of the total 'European' adult population. Personal at-home interviews, using a structured questionnaire, were conducted. The question asked was, "Do you agree or disagree that it should be made easier to obtain a legal

abortion in South Africa?"

Responses were divided into 'agreed', 'disagreed' and 'don't know'. The result showed a deep split in public opinion between the two language groups - the Afrikaans and the English. 41% of the total sample felt that abortion should be made easier and 47% disagreed with this. 57% of the English speaking sample agreed and 59% of the Afrikaans speaking sample disagreed. Women were found to have a slightly less liberal attitude towards abortion than men. 50% were not in favour of liberalizing the abortion laws, while 38% favoured this. 43% of the men were in favour of more liberalized laws. Of all the provinces, only Natal produced an absolute majority in favour of more liberal abortion laws; 51% agreed to the question as compared with 41% in the Cape, 39% in the Transvaal and 23% in the Orange Free State. The Orange Free State and the Transvaal both produced absolute majorities against liberalizing the laws, in the Orange Free State 57% and in the Transvaal 50% (See Appendix A). There is no data available about attitudes in other ethnic groups.

CHAPTER 3

LEGAL ASPECTS OF ABORTION

World Abortion Legislation

Abortion laws are influenced by the general attitude towards abortion in any given country, this being largely determined by the state religion, where there is such. Thus, in predominantly Roman Catholic countries such as Ireland and Portugal, abortion is absolutely prohibited. The same may be seen in countries which were originally colonized by Roman Catholics, e.g. in Dahomey and in the Malagasy Republic abortion is also prohibited. By contrast, in countries where religious beliefs are not strongly upheld by the state, abortion laws are more permissive, e.g. Russia.

Abortion legislation may be divided in the following way, according to the indications for therapeutic abortion:

1. Medical indications - to save the life of the mother;
   - to save the health of the mother.
2. Eugenic indications (foetal indications).
3. Ethical indications (humanitarian indications).
4. Medico-social indications.
5. Social indications.

It should be mentioned that in some countries, e.g. Spain, no explicit exemptions from the prohibition of abortion, not even when the life of the mother is at stake, is provided for in the penal code or in other legislation. Moreover in some countries, e.g. Ireland and Spain, publicity in favour of birth control and the sale of contraceptive devices or products are still prohibited.

Invariably when countries seek to liberalize legislation on abortion, the reason most frequently given is to reduce the number of criminal abortions. It is well known that in countries where restrictive legislation exists, the number of illegal abortions is extremely high. A woman who has decided

to get an abortion, will not be deterred by a refusal from the accepted medical channels. Though in some countries the abortion legislation may be fairly liberal, the number of criminal abortions may remain high. The reason usually given for this phenomenon is the woman's wish for complete privacy. Legal abortion invariably involves a stated procedure for assessment which some women wish to avoid in order to remain anonymous, and also to avoid the time-consuming assessment procedure.

Both the liberalization of abortion legislation and the imposition of restrictive measures may produce marked demographic changes, e.g. in 1966 Rumania passed more restrictive legislation and a year later showed a tripling of birth rates (World Health Organisation, 1971, p.5). Conversely, when more liberal legislation is introduced, the number of legal abortions increases while the number of births decreases, as do the number of deaths from septic illegal abortions.

In studying the evolution of legislative procedures on abortion, in most cases the initial indication is threat to the life of the woman and is contained within the penal legislation. In the course of time, the concept of maternal health (physical and psychiatric) is included in the exemptions in the penal code. When further liberal legislation is introduced, invariably a specific law is laid down governing the indications, contra-indications and the procedure for abortion.

The same evolutionary process may be seen in the indications given for therapeutic abortion. Initially complete prohibition may exist, but most frequently the initial indication is endangered maternal life. This later includes maternal 'health' (physical and psychiatric), then medico-social indications are specified which later extend to purely social indications, and abortion may then become legal on request. Denmark is cited as an example of this evolutionary process. The evolution of legislation of one country may be seen to influence the legislation of others, e.g. Iceland's influence on the Scandinavian countries (See Appendix B for

charts illustrating the evolution of world abortion laws).

When countries pass specific legislation on abortion, contra-indications may be listed. Such contra-indications may include the following (World Health Organisation, 1971):

1. Length of the pregnancy.
2. The presence of certain diseases in the woman.
3. A recent previous abortion.
4. Non-residency.
5. Consent of patient/spouse/parents.

Other provisions may also be included. Among these are specified the authorities who may be responsible for making the abortion decision, the place where the abortion may be performed and the reporting and recording of the procedure.

Following is a brief resumé of world abortion legislation discussed according to the indications for therapeutic abortion (Maps of these indications are given in Appendix C).

Europe

Until recently, Western and Southern Europe had taken a conservative approach to abortion legislation. Abortions were either completely prohibited or restricted to when the women's life was endangered.

In 1810, abortions were prohibited in France by the French Penal Code. Today France only recognizes abortions which are performed to save the life of the woman. These provisions were originally laid down in the Public Health Code of July 1939 and are also included in the Code of Medical Ethics and the Penal Code. Again, in Switzerland, provisions are laid down in the Penal Code, which permits abortion if the woman's 'health' is endangered. In the United Kingdom, until the Abortion Act of 1967, abortion constituted an offence according to the Offences against the Person Act of 1861, which prescribed that 'unlawfully' induced abortion was a crime punishable by life imprisonment. However, no definition of the term 'unlawful' was given. The Infant Life Prevention

Act of 1929 allowed for abortion to be performed if the life of the woman was endangered. In 1938, Aleck Bourne tested this law by performing an abortion on a 14 year old girl who had been raped. He was acquitted and the law was then interpreted as allowing abortion if the 'health' of the woman was endangered. In 1967 a specific Abortion Act was passed by the British Parliament which laid down the indications for therapeutic abortion. These included risk to the physical or mental health of the woman or similar risk to any existing children, as well as allowing for eugenic indications.

On the whole, Eastern European countries are found to have a more liberal approach than exists in Western Europe.

In terms of the Penal Code of 1956, abortion on request was introduced in Bulgaria. Due to the large numbers of abortions performed over the next decade and to combat abuse of the law, the Penal Code was reformed in 1968. The new provisions laid down that abortion on request was permitted up to the 10th week of gestation and up to the 12th week by application to a head of a department of gynaecology.

In Czechoslovakia in 1957, a specific abortion law was passed with repeal of the Penal Law of 1950. Both allowed abortion on 'health' grounds. In 1966 the Abortion Law was amended and extended to include medico-social indications.

In Eastern Germany legal abortion was permitted only on medical grounds during the period 1946-1947. In 1947 these extended to include medico-social, ethical and eugenic grounds aiming at the suppression of criminal abortion. The appropriate sections of the Penal Code of 1871 were repealed. In 1950 a change in the law reduced the indications for therapeutic abortion to those of maternal 'health'. In 1965 the indications were widened to include social indications, and in 1972 abortion became available on request.

Until 1952 abortion was allowed in Hungary solely on medical indications. The law was liberalized in 1953 to provide for medico-social and eugenic indications, and again in 1956 to cover purely social indications. In practice,

abortion is available on request. In Poland, under the terms of the law of October 1950 on the medical profession, abortion was permitted only if the 'health' of the woman was in danger. In 1956 the law was amended to include medico-social indications and these indications were further widened by another amendment in 1959.

In Russia, during the period 1917-1920, all abortions were prohibited. In 1920 a decree issued by the People's Commissariates of Health and Justice, legalized abortion to include 'health' and social indications, with the aim of combatting illegal abortions. A considerable increase in the number of abortions resulted. To counteract this, restrictive legislation was reintroduced in 1936 and limited therapeutic abortion to 'health' and eugenic indications. In 1955 the legislation was completely repealed to allow abortion on request.

"A relatively uniform policy in regard to legal abortion has been introduced by the Scandinavian countries, even if they have done so at different times" (World Health Organisation, 1971, p.59). The overall trend is towards a progressive liberalization of the indications for therapeutic abortion, resulting in a considerable increase in the number of abortions performed.

The 1930 Civil Criminal Code of Denmark made no provisions for cases where abortion was not punishable, but in practice abortions were performed in order to save the 'health' or life of the woman. The Law on the Interruption of Pregnancy of 1937 laid down specific indications for therapeutic abortion. These included medical, ethical, eugenic and medico-social indications. In 1956 and 1970 further amendments extended the social indications of therapeutic abortion and in 1973 abortion became available on request.

Prior to the 1950 Law on the Interruption of Pregnancy, abortions in Finland were only permitted in order to save the life of the woman. The Law on the Interruption of Pregnancy extended the indications to preserving the 'health' of the woman. In 1956 the law was amended to include medico-social indications. A further amendment in 1970 extended the

grounds to include 'social' indications.

Iceland was the first Scandinavian country to pass a law relating specifically to abortion and introduced the concept of medico-social indications. The Abortion Law was passed in 1935 and is still in operation. It was not until 1960 that a specific law on abortion was passed in Norway. However, this law included medical, medico-social and eugenic indications. The basic abortion legislation in Sweden dates from 1938 with the Law on the Interruption of Pregnancy and its subsequent amendments in 1946 and 1964. From 1938 the law included medico-social indications.

Africa

"Most of the newly independent African states have retained, as far as abortion is concerned, the legislation introduced by the colonial country" (World Health Organisation, 1971, p.22). This has led to a generally conservative handling of the abortion decision, since most of the colonial countries had a restrictive approach to the question.

The English speaking countries of Africa have remained, to a large extent, under the provisions laid down in the Offences against the Person Act of 1861 and the Infant Life Preservation Act of 1929. An exception to this is Zambia where in 1972 an Abortion Act was passed which was modelled on the British Abortion Act of 1967 and included the 'environmental' clause.

The same pattern exists in the French speaking countries, e.g. Ivory Coast, Senegal and Algeria all adopted the provisions laid down in the French Public Health Code of 1938, which only permits abortion in order to save the life of the woman. Exceptions to this are Morocco, Cameroon and Tunisia. All initially adopted the 1938 French Public Health Code, but since then Morocco has extended the indications to include threat to the 'health' of the woman (1967), Cameroon amended the Penal Code in 1967 to include threat to the 'health' of the woman, and in Tunisia in 1965 the Penal Code was amended to include medico-social indications.

Ethiopa modelled her provisions for therapeutic abortion, which are still contined in the Penal Code of 1957, on those of Switzerland. Abortion is permitted on medical indications to save the life and the 'health' of the mother.

The South African Abortion and Sterilization Act 2/75, which is applicable to South Africa and South West Africa, will be discussed later in this chapter.

Australasia

The legal provisions governing abortion in Australia are contained in the various penal legislation of each state. Initially provisions were laid down by the Offences against the Person Act of 1861 and the Infant Life Preservation Act of 1929. None of the states have specific abortion laws. Throughout Australia, the indications for therapeutic abortion are danger to either the life or the 'health' of the woman.

The abortion legislation of New Zealand is in the same position as Britain prior to the Abortion Act of 1967. The Offences against the Person Act of 1861 and the Infant Life Preservation act of 1929, as well as the Crimes Act of 1908, limit the indications for therapeutic abortion to threat to the 'health' of the woman.

The Americas

Many of the South American countries still have their exemptions for abortion contained in their penal codes. On the whole, the South American countries have taken a conservative stand with regard to therapeutic abortion.

In the Dominican Republic, according to the Penal Code of 1938, abortion is completely prohibited. In Columbia, according to the Code of Medical Ethics Decree of 1954, the same situation exists.

Chile, Paraguay, Peru, Uruguay and Venezuela all permit abortion only to save the life of the woman. In Chile this provision is found in the Sanitary Code of 1967, in Paraguay in the Penal Code of 1914, in Peru in the Sanitary Code of 1969, in Uruguay in the Penal Code of 1938, and in Venezuela

in the Penal Code of 1964. Exceptions to this restrictive approach to abortion are found in Cuba, Argentina, Brazil and Ecuador. Argentina, Brazil and Ecuador all permit abortion to save the 'health' of the woman. In Argentina this is laid down in the Penal Code of 1967, in Brazil in the Penal Code of 1940 and in Ecuador in the Penal Code of 1938. Cuba has more extended indications for therapeutic abortion. These are laid down in the Social Defence Code of 1938 and include 'health', eugenic and ethical indications.

In Mexico the Penal Code of 1931 prescribes that abortion is not permissible unless performed to preserve the life of the woman or on ethical indications.

Until 1969, Canadian abortion legislation was still contained in the Offences against the Person Act of 1861, where abortion was permitted only to save the life of the woman concerned. In 1969 the Criminal Law Amendment Act was passed which made abortion permissible on the grounds of a threat to the life or 'health' of the woman, and on ethical and eugenic indications.

In the United States of America, prior to the middle of the last century there was no legal prohibition against abortion before 'quickening'. A change of attitude occurred in the second half of the 19th century, largely as a result of the need to combat illegal abortions. Initially four states provided for no exceptions to the prohibition on abortion. These were Louisiana, Massachusetts, New Jersey and Pennsylvania. In 46 states abortion was permissible to preserve the life of the woman and some included the 'health' of the woman (e.g. the District of Columbia and Alabama). No precise definitions of the terms 'to preserve life' and 'health' were given. An important role in the liberalization of these laws occurred when the American Law Institute put forward the Model Penal Code provisions in 1959, later modified in 1962. These provisions permitted abortion to be performed by a qualified practitioner where:

1. There is a danger to physical or mental health of the woman.

2. The pregnancy was caused by rape or incest.

3. There is a probability that the child to be born will be mentally retarded or physically deformed.

In 1967 the American Medical Association adopted a policy on termination of pregnancy based on these provisions. The first state to do this was Colorado in 1967. Thereafter several other states followed suit, with various modifications. A number of states adopted more liberal abortion laws than were laid down in the Model Penal Code. In Alaska, Hawaii and New York, abortion is available on request.

In 1973 the United States Supreme Court ruled that "while a woman has no absolute constitutional right to abortion, the laws prevailing in some states did curtail her constitutional rights; that in the first 12 weeks of pregnancy, the decision should be for her and her medical adviser alone, but that thereafter, the State might regulate the abortion procedure in ways reasonably related to maternal health, including proscribing it after the stage when the foetus might be presumed viable, except where necessary to preserve the life of the mother" (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.222).

Asia

In most of the Asian countries, abortion legislation is restrictive and is a punishable offence if performed other than to save the life of the woman. Cambodia, the Republic of Korea, Pakistan, Thailand, India and Singapore all derive their abortion laws through their penal codes. In Cambodia the Penal Code of 1934 allows abortion to save the life of the woman, likewise the Penal Codes of Pakistan (1860), India (1860) and Singapore (1875) lay down that abortion is not punishable if performed to preserve the life of the woman. India, however, introduced an Abortion Act in 1972 which allows for abortion on both 'health' and medico-social indications. Likewise, in 1970 Singapore introduced an Abortion Act which included 'health' and medico-social indications. Abortion is prohibited by the Penal Code of 1953 in the Republic of Korea and also in Syria by a Decree of

1962.

Israel initially was governed by the provisions of the Offences against the Person Act of 1861, but in 1952 an Abortion Law was introduced which permitted 'health' and medico-social considerations as indications for therapeutic abortion.

Under Section 22 of the Turkish Law of January 1960 on Medical Ethics, abortion was only permitted where this constituted the sole means of saving the life of the woman. In the Law on Family Planning in 1965 and the Regulations of 1967 concerning the interruption of pregnancy, abortion is authorized if the 'health' of the mother is endangered or where there is risk of congenital defect. Turkey also accepts failure of the IUD without expulsion as an indication.

Japan's provisions concerning therapeutic abortion are contained in the Eugenic Protection Law of 1948 and as amended in 1960. Previously the National Eugenic Law of 1940 had been in force. This law allowed abortion on 'health' grounds only. The 1948 law extended the indications to include medico-social considerations and in 1960 it was amended to include extended social indications.

Abortion in South Africa - The Abortion and Sterilization Act 2/75

Under South African Roman Dutch Law, there was no legal coverage for therapeutic abortion performed on psychiatric grounds, although it was established in Common Law that a pregnancy could be terminated in order to save the life of the mother. Thus, the traditional view was that the sole ground recognized by South African law was to save the life of the mother.

In South Africa in 1968, Simonsz (1968, p.717) stated that "psychiatric indications for therapeutic abortion of pregnancy do exist and every case must be judged on its own merits, avoiding every kind of dogmatism in making an assessment." He discusses a number of points which are of specific note in

the abortion decision.

Firstly, the affective illnesses, he states, are well-known for their return to almost normality in between psychotic episodes, but their relationship to a number of pregnancies is noteworthy. He states that "these psychoses carry with them an increased probability of suicide" (1968, p.717). Secondly, schizophrenia is seen as a chronic relapsing illness which creates damage to the personality, thereby making a satisfactory mother-child relationship virtually impossible. This illness, he feels, should be considered carefully in the abortion decision, particularly in its relation to its effect on any previous pregnancies. Puerperal psychosis is a very rare illness but with regard to its recurrence in pregnancy, the guideline should be related to its probability of being a chronic disabling illness. Threats of suicide in relation to an unwanted pregnancy are common, particularly in a female who is manipulating for a positive abortion decision. Although such threats are often brushed aside, the fact that suicide might occur necessitates specific handling of this problem in each individual case. Likewise, threats of illegal abortion are relatively common. In this instance, the number of patients who need and obtain such abortions is considerably higher than those who threaten and attempt suicide.

Simonsz discusses social indications and points out the incongruity of how in general psychiatric practice, environmental factors are given consideration but in an abortion decision, legislation can prevent such considerations. Ethical indications do not appear to have caused difficulty in the abortion decision, providing the Attorney General has been consulted. Eugenic indications are of uncertain prediction and according to Simonsz "no strong legislation can be mustered" (1968, p.717). The aspect of guilt feelings is discussed in numerous articles and books, but should be equally considered along with the woman's persistent desire for abortion.

A further consideration, as noted by Simonsz, is that of the mentally retarded female who does not grasp the fact that she is pregnant. Such a female would be incapable of the role of motherhood in either the emotional or physical sphere. Retardation seems to have been accepted as a clear psychiatric indication in the past.

In 1971 Keast, the then President of the Border Coastal Branch of the Medical Association of South Africa, discussed the necessity of changing abortion laws in South Africa in relation to the areas of criminal abortion, population control, physical and mental health of the mother, congenital abnormalities and socio-economic factors.

He noted that "one of the main arguments in favour of legalizing abortion and of extending its indications is that the present practice, based essentially on Hippocratic principles, encourages criminal abortion with all its attendant hazards" (1971, p.888). However, information from other countries has shown that the criminal abortion rate does not really drop until extended socio-economic indications are permitted or if abortion is performed on demand. "It is obvious that the only way to eliminate criminal abortion is to permit unrestricted legal abortion on the demand of any pregnant woman" (Keast, 1971, p.888).

Therapeutic abortion has proved to be a powerful weapon in influencing the birth rate, e.g. in Rumania the birth rate dropped to such an extent by 1965 that more stringent legislation was passed and the birth rate then began to rise.

Today, very few abortions are performed on medical indications. However, psychiatric indications are given in a large majority of cases in various countries, particularly where abortion is not permitted on medico-social or social indications. Keast suggests, therefore, that careful "consideration should be given to the physical and mental health of the woman" (Keast, 1971, p.889).

In many countries, congenital abnormalities provide an acceptable indication for therapeutic abortion. However,

it should be noted that for every malformed foetus, about five or six babies will be destroyed (Keast, 1971). Whether socio-economic indications for therapeutic abortion should be permitted or not has long been debated. There is a fear that if this should be permitted, the system would be abused, women could revert to it instead of using reliable contraceptive measures, and that the size of the population might be adversely affected. However, it is well-known that women long to be free from the risk of repeated pregnancy, the effect of large families on the standard of living and the psychological aspects of 'unwantedness' on the child. Against this background, the rights of the foetus versus the rights of the woman are fought out.

Keast (1971, p.891) makes a number of suggestions in relation to the statutory measures of legal reform of abortion in South Africa.

1. "That a conscience clause should exist to release unwilling doctors or institutions from participating in the abortion decision.
2. A residential clause to avoid becoming an abortion 'mecca'. In England foreign women represent about 10% of the total number of abortions, while in the private sector the figure is much higher.
3. Compulsory notification of the details of every legal abortion for statutory purposes.
4. Approval should be given by two or three doctors rather than by committees or boards, as in the United States of America.
5. An upper time limit of 14 weeks, unless the mother's life is endangered by the pregnancy."

The above two articles by Simonsz and Keast are among the very few written and printed in South Africa attempting to clarify the indications for legal abortion prior to the legislative reform.

In March 1972 the South African Medical and Dental Council

laid down the following guidelines for therapeutic abortion. They considered therapeutic abortion was ethically justifiable in order to protect the life and health of the pregnant woman, in cases where there was real danger that an abnormal child was to be born, and in instances of rape, incest or where the woman concerned was unable to understand the result of coitus.

In 1973 a Bill entitled 'The Abortion and Sterilization Bill' was brought before the South African Parliament. The aim of the Bill was to lay down the circumstances under which a therapeutic abortion might be obtained, the procedure for assessment, and the place where such operations might be performed. Paragraph 3, subsection 1 laid down the following circumstances under which a therapeutic abortion could be obtained:

"a. where the continued pregnancy may endanger the life of the woman concerned or may constitute a serious threat to her physical health and two medical practitioners certify in writing that the continued pregnancy might, in their opinion, so endanger the woman concerned or so constitute a threat to her health; or

b. where there is a substantial risk that the child to be born will suffer from a physical or mental abnormality of such a nature that it will be seriously handicapped, and two medical practitioners certify in writing that, in their opinion, based on medical scientific grounds, there is such a risk; or

c. where the foetus is alleged to have been conceived in consequence of unlawful carnal intercourse and

(i) two medical practitioners certify in writing

(aa) in the case of rape or incest, and after such interrogation of the woman as any of them may deem necessary, that the pregnancy is, on a balance of probability, due to alleged rape or incest, as the

case may be; or

(bb) in the case of carnal intercourse which is alleged to have been in contravention of section 15 of the Immorality Act 23/57 that the woman concerned is an idiot or imbecile; and

(ii) a certificate issued by a magistrate under section 7(3) is produced to the medical practitioner referred to in section 7(1)."

Abortion was also recommended in the case of carnal intercourse where the woman is under the age of 16 years, in contravention of section 14 of the Immorality Act 23/57. The two medical practitioners who might issue the certificate, were not permitted to either assist at or participate in the actual operation. At least one of the two medical practitioners had to have been practising as a medical practitioner for at least five years since his date of registration. In cases of alleged rape, one of the medical practitioners was to be a District Surgeon and one had to be a psychiatrist where abortion was sought under subsection (1)(a). This latter was the only reference to psychiatric assessment in the Bill. Provisions were made for abortion in emergency cases. The place of abortion was restricted to a state institution or provincial hospital. The approval of the medical superintendent was also required. A report of the operation was to be sent to the Secretary for Health within 21 days of the operation.

These recommendations were subsequently modified in the Abortion and Sterilization Bill of 1974. Paragraph 3 subsection 1 laid down the modified indications for therapeutic abortion as follows:

"a. where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health and two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy

so endangers the life of the woman concerned or so constitutes a serious threat to her physical health and abortion is necessary to ensure the life or physical health of the woman;

b. where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned, and that two other medical practitioners have certified in writing that, in their opinion, the continued pregnancy creates the danger of permanent damage to the woman's mental health and abortion is necessary to ensure the mental health of the woman;

c. where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped, and two other medical practitioners have certified in writing that, in their opinion, there exists on scientific grounds, such a risk; or

d. where the foetus is alleged to have been conceived as a consequence of unlawful carnal intercourse and two other medical practitioners have certified in writing -

(aa) in case of alleged rape or incest, after such interrogation of the woman concerned as they or any of them may have considered necessary, that in their opinion, the pregnancy is due to the alleged rape or incest, as the case may be; or

(bb) in the case of alleged unlawful carnal intercourse in contravention of section 15 of the Immorality Act 23/57, that the woman concerned is an idiot or an imbecile."

Thus, in the modified version, the psychiatric indications for therapeutic abortion had to constitute a risk of permanent damage to the mental health of the woman. Three medical practitioners had to assess the woman's case and all three

agree prior to the operation. Instead of any psychiatrist assessing the indications laid down in Paragraph 3 subsection b, the 1974 Bill specifically indicated that only a psychiatrist employed by the State might make such an assessment. Again it was recommended that all abortions be performed in State controlled institutions or any other institutions so designated by the Minister of Health. Again, the medical superintendent was required to give consent for the abortion. The age clause in contravention of section 14 of the Immorality Act 23/57 was completely omitted. It became necessary that in order to gain an abortion on ethical grounds, a complaint of rape must have been submitted to the police previously and such documents to be made available in order to verify the rape. Again the District Surgeon was required to be one of the three doctors recommending or not recommending therapeutic abortion. A report by the medical practitioner had to be submitted, in all cases, to the Secretary for Health within 21 days of the operation. A conscientious objector's clause was included in the 1974 Bill in order to release reluctant staff who objected to therapeutic abortion from having to participate in the procedure.

The modified Abortion and Sterilization Bill of 1974 became law in March 1975 as the Abortion and Sterilization Act 2/75. It is clear that the Act is a lot more stringent than the 1973 Bill. No provision is made for girls under the age of 16 years and no definition is made of the term 'rape'. Psychiatrists are only specifically mentioned under the clause relating to abortion performed solely on psychiatric indications. It is obvious that abortions under any of the clauses mentioned are of relevance to psychiatry. Favourable or adverse effects on emotional wellbeing may follow therapeutic abortion performed under any of the clauses. Psychiatrists may more particularly find themselves involved where there is a risk that the child to be born may be seriously mentally handicapped or in cases where the woman concerned is an idiot or imbecile, but in neither case is a psychiatric opinion obligatory. The wording of Paragraph 3

subsection (b) is difficult to apply in the assessment for therapeutic abortion, when threats of suicide or illegal abortion are frequently made. It involves the most difficult area of psychiatry, i.e. prognosis. It is extremely difficult to assess or predict 'permanency'. Paragraph 3 subsection (3)(b) states that assessment must be made by a psychiatrist employed by the State. This leads to a few psychiatrists carrying the burden of assessment. It is obvious that the difficulty of access to such a service is likely to occur in underdeveloped areas. It also implies a slur on private psychiatrists and removes the right of the woman to make her own choice of practitioner.

Performing all abortions in a State controlled institution also removes the right to privacy of the individual, as does the necessary reporting and documentation required by the Act. Again difficulty of access to such institutions occurs in underdeveloped areas, as well as the ability of such institutions to carry the extra load of abortion cases along with routine gynaecologic and obstetric work.

The conscientious objector's clause does not require the medical practitioner to refer the woman to a colleague who does not object to taking part in assessment. Thus, a woman's right to a fair, unbiased assessment for therapeutic abortion could be abruptly halted.

However, with all these criticisms, it is important to note that a legal stand was made and that there are legislative guidelines on which a medical practitioner may make his assessment. Such an Act provides a setting against which recommendations and modifications may be made.

Criminal Abortion and Abortion Laws

Abortion is not unique to any society or any period in history. It dates back to antiquity and women, regardless of age, social class or religion, have reverted to it if they have become pregnant against their will. Due to the fact that abortion today, in most countries, is only permissible if certain risks are present, the problem of illegal abortion

has arisen. Cloete (in Oosthuizen et al, 1971, p.141) defines criminal abortion as "an untimely delivery, voluntarily procured with the intent to destroy the foetus before natural birth." Therefore, it may be stated, that restrictive laws combined with the woman's determination to obtain an abortion, contribute to the existence of the criminal abortionist.

Abortion is and has been very much part of our social culture, but it forms a part which is seldom mentioned (Bates and Zawadzki, 1964). The silence appears to be related to the general taboo on discussion of sex in general, which until the present was very prudish in outlook.

It is virtually impossible to obtain accurate statistics in the area of illegal abortion, but it is well known that the number is substantial. However, the rate of the conviction of the criminal abortionist is very low. A number of factors lie behind the discrepancy between the act committed and the offenders convicted. Firstly, in order to establish guilt in an abortion trial, very definite, objective and ample evidence is necessary. This is extremely difficult to obtain after the act has been committed and even the juries are sometimes reluctant to convict. Illegal abortion as a crime, is difficult to detect unless complications or death occur. The offender has been considered guilty of a crime in the past, but was seldom prosecuted. The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.158) cites the following reasons for the difficulty in convicting either the woman or the illegal abortionist:

1. "Pregnant women who abort themselves or knowingly obtain an illegal abortion are guilty of a criminal offence which, like any other crime, they naturally wish to conceal.

2. Even though it is the practice not to prosecute a woman for availing and abetting an abortion upon herself and even though she is informed of this, she usually desires to avoid being called as a witness in a criminal case and is likely to

be unhelpful to the police in their enquiries.

3. Without the evidence of the woman concerned, and sometimes even with it, it may be difficult to prove that she was in fact pregnant. This is particularly the case where the person charged with illegal abortion is a registered medical practitioner: the prosecution would have to show that the operative procedure carried out was in order to procure an abortion and not, for example, dilation and curretage for reasons unconnected with pregnancy, or treatment for spontaneous abortion."

Illegal abortion may be either self-induced, induced illegally by a medical practitioner, or induced by a 'back-street' abortionist. Before making the attempt to gain an illegal abortion, most women attempt to abort themselves. Peter Tarnesby (Hordern 1971, p.3) has been quoted as classifying the drugs commonly used in self abortion as follows:

1. "Purgatives and emetics such as castor oil, aloes and colocynth.
2. Substances causing uterine contraction - ergot, oxytocin, oestrogen and quinine.
3. Herbal oils producing pelvic congestion - the essential oils of bergorrot, juniper (gin), rue, saffron, nutmeg, penny royal, tansy, savin and laburnum.
4. Local application to the vagina - mercury salts, copper sulphate, lead preparations and potassium permanganate: and
5. Specific drugs such as folic acid, which deprive the foetus of essential vitamins."

In order to be effective, these substances have to be used in near-fatal doses and in producing abortion, they may severely poison or even kill the woman (Hordern, 1971). If these measures fail, the woman may attempt douching under

pressure or may resort to local interference with knitting needles, scissors, pencils or other such objects. These are pushed into the vagina or cervix, often accompanied by dangerous results. When these attempts fail, the woman may resort to the illegal abortionist.

Bates and Zawadzki (1964, p.95) isolates five different people who may practice as criminal abortionists:

1. "The physician-abortionist.
2. The abortionist with some medical training, e.g. nurses, midwives, physiotherapists, dentists, etc.
3. The 'quack' doctor, i.e. unlicensed general practitioner with little or no formal training but who presents himself as a duly licensed physician.
4. The amateur type - these persons enter the abortion field from extremely diverse prior activities and include salesmen, prostitutes, etc.
5. The self abortionist."

Records show that the abortionist is patronized by women of all social classes, economic levels and educational backgrounds. It is also true that criminal abortion is far more prevalent in urban than in rural areas.

Over 80% of convicted abortionists are women (Gardner, 1972, p.25a). Most have sufficient knowledge not to attempt abortion on women with pregnancies of more than 12 weeks gestation. Moya Woodside (Hordern, 1971, p.4) a psychiatric social worker, interviewed forty-four women abortionists sentenced to Holloway Prison in the early 1960's and found that most were lower middle class women aged between 50 and 70 years. They did not perceive abortion as a crime and asserted that they had wanted to help women with unwanted pregnancies out of sympathy for their situation. They denied that financial gain was their objective and their fees were lower than for 'illegal medical' abortions.

Illegal medical abortions performed for money and perhaps out of sympathy, are much rarer than 'backstreet' abortions and may be carried out in the practitioner's surgery or in premises obtained for this purpose. Prior to the Abortion Act of 1967 in England, liberal gynaecologists had long practised illegal abortions, using the precedent of the Bourne case. Supported by the opinion given 'in good faith' by a psychiatrist that a continuation of pregnancy would be detrimental to the mental health of the pregnant woman, a few gynaecologists were prepared to terminate an unwanted pregnancy in its early stages, though they were much more reluctant to do so after the first trimester (Hordern, 1971, p.4).

From the above, the age-old discrepancy between those of a higher income group and those from a lower income group is shown. The wealthier clientele usually gain illegal abortion privately via the physician-abortionist, whereas the woman from the lower socio-economic income group is driven to the unskilled 'backstreet' abortionist. The poorer woman is therefore at greater risk.

Psychological consequences, e.g. guilt, produced by the intentional destruction of life, the breaking of a religious rule, or fear of legal sanctions, have been reported as infrequent (Viel in Hall, Vol. I, 1970). Viel (in Hall, Vol. I, 1970, p.233) states that the less educated woman apparently does not associate abortion with killing a human being and when she has an abortion, she feels like a soldier killing an unknown enemy in an act of war.

It has been postulated that a woman undergoing an illegal abortion might be inclined to have more guilt feelings than a woman gaining an abortion legally. However, it has been found that this is not so and that guilt feelings are equally likely in either instance (Osofsky et al, 1971). Psychiatrists see almost none of the large numbers of women who have obtained illegal abortions and when interviewed, they report few problems. Osofsky (1972, p.49b) points to

research carried out by Gebhard who studied 442 American women who had induced abortions, most of the procedures having been performed illegally. "Their results demonstrated only rare significant physical or emotional sequelae."

One of the principle reasons put forward for liberalization of abortion laws is that it would reduce the number of illegal abortions. We are now in a position to attempt to see if this is verified by looking at countries with liberalized laws. The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.154) cites a number of estimates of illegal abortion in England prior to the Abortion Act of 1967. These included:

1. "1939. The Report on the Inter-Departmental Committee on Abortion suggested that 110 000 - 150 000 abortions were performed annually, of which 40% were illegal.

2. 1966. The Report of the Royal College of Obstetricians and Gynaecologists referred to estimates given as 50 000, 100 000 and 250 000 respectively.

3. 1966. Mr. Phillip Rhodes, F.R.C.S., F.R.C.O.G. in 'Abortion in Britain' suggested a figure of 87 000.

4. 1966. A national opinion poll produced a figure of 30 000.

5. 1971. Dr. W.H. James in 'Population Studies', Vol. XXV, No. 2, p.327, referred to 60 000.

6. 1972. Professor H.L.A. Hart and David Soskill in the Guardian newspaper of 3/5/72 referred to the number 66 000 as being a 'very conservative estimate'.

7. 1972. Dr. C.B. Goodhart in 'Population Studies' 16th August, mentioned earlier estimates he had made and concluded that "the true rate would not have exceeded 20 000 and probably nearer 15 000."

The two main measures of the extent of illegal abortions are the number of septic abortions presenting for treatment and the number of maternal deaths recorded and the number of prosecutions made. The latter, as stated previously, present very low figures. In Britain the Abortion Act became law in 1968. In the same year 68 people were prosecuted for performing illegal abortions and 60 were found guilty. In 1969 the total was 59, with 52 people found guilty, 1970 43 people were prosecuted and 41 found guilty, in 1971 the number of prosecutions had dropped to 38 with 36 found guilty and in 1972 the total number of prosecutions was 34 with 25 found guilty (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.156). Thus, it can be seen that the number of prosecutions had dropped in Britain since the inception of the Abortion Act. The Report on Confidential Enquiries into Maternal Deaths in England and Wales 1967-1969, shows that deaths attributed to illegal abortions totalled 28 in 1967, 29 in 1968 and 17 in 1969 (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.154). The Hospital Inpatient Enquiries also showed an overall fall in categories of abortion other than those performed therapeutically.

A clear effect of the results of liberalized abortion laws on the number of criminal abortions may be obtained by looking at the Eastern European countries where abortion was liberalized in Russia in 1955, in Bulgaria, Hungary, Poland and Rumania in 1956, in Czechoslovakia in 1957 and in Yugoslavia in 1960. Hordern quotes Professor Mekland as observing that in all these countries legal abortion has been associated with a reduction of criminal abortions and decline of the birth rate (Hordern, 1971, p.67).

However, a study of the outcome of all pregnancies between 1950 and 1965 in Stockholm, carried out by Holdt, indicated that despite the advent of legal abortion, the criminal abortion rate had not decreased to any large extent. This bears out the fact, previously noted, that some women will continue to use illegal means of gaining an abortion in order

to maintain anonymity and avoid the abortion formalities concerning enquiries, certificates, hospital admission, etc. (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974).

Seward et al (1973) note that during the first year, 1970, of New York's liberal abortion laws, there was a drop from 12 to 6 deaths from illegal abortions. However, Kahan et al (1975) state that it was only after three years of legal abortion that the decline in illegal abortion complications began. It is obvious that the availability of abortion services must be sufficiently broad in order to obviate having to resort to criminal means. Improved contraceptive usage is an alternative explanation for the decrease in illegal abortions, but this is not substantiated by the other trend, that of increased legal abortions.

Between 1947 and 1964, New York's birth rate was on a continuous rise. In 1964 a downward trend began which reversed itself before 1970 and births were again on the rise. Demographers predicted that the birth rate would increase steadily in the 1970's because of the increased number of women in the child bearing ages stemming from the 'baby boom' in the late 1940's. Thus the decline in the birth rate observed for 1971 after the introduction of New York's liberalized abortion law of 1970, is noteworthy (Harris et al, 1973). Again the numbers of out of wedlock babies after a steady rise, declined in 1971.

In South Africa, Cloete (<u>in</u> Oosthuizen et al, 1974) stated, before the Abortion and Sterilization Act 2/75, that it could be assumed that illegal abortions constituted well over 90% of all abortions. This was illustrated by the hospitalization of women who suffered from the after effects of illegal abortion. In 1970, Groote Schuur Hospital treated 1820 septic abortions. A special abortion unit is maintained and it has the highest bed occupancy and patient turn over of all the wards. In Durban the King Edward VIII Hospital repairs 4000 septic abortions annually (Cloete <u>in</u>

Oosthuizen et al, 1974, p.146) prior to the inception of the Abortion and Sterilization Act 2/75. Researchers have previously estimated that 250 000 criminal abortions are performed annually in South Africa (Cloete *in* Oosthuizen et al, 1974, p.146).

Cloete (*in* Oosthuizen et al, 1974) suggests three factors which might help reduce the incidence of criminal abortion:

1. Widespread education, particularly sex education and contraception.
2. A more flexible abortion law is needed and the administration procedure, which causes delays, should be streamlined.
3. The law should protect the wellbeing of the woman by allowing her greater opportunity to have an abortion performed in a hospital under safe conditions and where medical attention is available.

CHAPTER 4

PSYCHIATRIC ASPECTS OF THERAPEUTIC ABORTION

The Role of the Psychiatrist

The psychiatrist's participation in the abortion decision has steadily increased since the 1950's. As medical science has advanced, the number of medical indications for therapeutic abortion has fallen. It appears that the psychiatric route has become more and more the only way for a woman to get a legal abortion. "It seems as if the psychiatrist was exploited in an attempt to satisfy a social need within the context of the medical model" (Babikian *in* Friedman et al, 1975, p.1498). Under these conditions a dilemma is created for the psychiatrist. He is faced with the task of refusing women who do not meet stringent psychiatric criteria, with the knowledge that these women will go from legitimate medical services to the dangers of the 'backstreet' abortionist.

In the late 1960's and early 1970's, psychiatrists began to voice the complaint that they were being exploited and that abortion should be an issue between the woman and her gynaecologist. Just before the passing of the British Act in 1967, 90% of all abortions were performed on psychiatric grounds (Hordern, 1971, p.180). However, the psychiatrist was drawn into the abortion decision firstly on account of his medical background, which teaches him to see the patient in terms of the total environment, and secondly his training makes him always consider prevention (Babikian *in* Friedman et al, 1975). He is trained to be aware of a multiplicity of factors, individual, social, legal and religious.

Gardner (1972a) discusses the relationship between the gynaecologist and psychiatrist in England and states that frequently the opinion and judgment of the psychiatrist are not taken seriously in the abortion decision. It is important to note that in the British Abortion Act of 1967, no provision was made requiring sanction by a psychiatrist when

an abortion was to be performed on psychiatric grounds. In this way, it has come about that only a few selected cases have been referred to the psychiatrist in Britain since the Abortion Act of 1967, although prior to the Act use had been made of psychiatric opinion. Four reasons may be seen as contributing to the gynaecologist's reaction to a psychiatric opinion (Gardner, 1970, p.230a).

1. The whole field of psychiatry is poorly defined and some practitioners appear to consider it has no bounds. The psychiatrist is confronted with the limitations of psychiatry in the abortion decision. He has no actual scientific base on which to make his decision. He almost becomes a practising moralist.

2. Unlike specialists in other fields whose views vary only within narrow limits, psychiatrists appear to have no agreed course, treatment and diagnosis for many medical conditions. This large range of opinion becomes even more evident in the abortion decision, where recommendations range from those who never recommend a therapeutic abortion to those who always do, from those who regard pregnancy as definitely increasing the incidence of mental illness, to those who feel that pregnancy represents virtually no additional stress. This is very far from the scientific objectivity which is regarded as essential in the abortion decision.

3. During the period when abortion laws were stringent, psychiatrists allowed themselves to be manipulated. Over a 10 year period before 1962, psychiatric recommendations rose from 8,2% to 40% of all therapeutic abortion cases in New York State. It appears that medical practitioners had seen an 'easy way out'.

4. The gynaecologist finds it difficult to accept

some of the recommendations made by psychiatrists and in turn refuses to accept them.

White (in Hall, Vol. II, 1970) attempted to clarify the psychiatric indications for induced abortion through discussion with other disciplines involved, i.e. people in the fields of law, religion, gynaecology and obstetrics. He could find no specific results and concluded that there were three main factors causing this confusion:

1. There is a lack of systematic, properly gathered data on the effect on a woman of being either granted or refused an abortion.
2. Men (physicians, clergy, lawmakers) not women, have the predominant say in setting policies and laws governing abortion, and the abortion issue tends to invoke in men powerful, unconscious conflicts and motivations. These conflicts impair rational judgment and decisions.
3. The problem is usually considered simultaneously from a variety of view points - scientific, legal and theological.

In any therapeutic relationship, it becomes increasingly difficult to maintain objectivity when no specific physical ailment is present to give a base for measurement. Thus, it appears that there is a large subjective element involved in the way psychiatric information is interpreted. This difficulty is magnified in the abortion decision, which embraces legal, religious, moral, ethical and physical aspects. In the interpretation of such words as 'mental health', 'happiness', 'normal reaction', 'depression' and 'in good faith', all reflect the outlook of the individual who has to turn to his own reference system in interpreting them.

Thus, it appears the psychiatrist not only has to overcome the suspicions of his colleagues in his diagnosis, but he must also attempt to defend a position which is less

demanding in other medical fields. He is also confronted by further difficulties which are not present in other branches of medicine. There is the question of frankness and honesty on the part of the patient. Gynaecologists have their own objective findings on which to base their decisions, the psychiatrist must rely almost entirely on the word of his patient. Many patients hide their true feelings or refuse to show any ambivalence in their efforts to gain a therapeutic abortion. There is the uncertainty of the patient's future reaction, either to therapeutic abortion or to the continuation of the pregnancy. There is the paradox that the mentally ill frequently find it more difficult to stand the stress of an abortion. This means the greater the psychiatric indications for therapeutic abortion, the greater the risk of unfavourable sequelae after the operation. The psychiatrist must also attempt to weigh up the ability of the woman to cope with the baby if it were to be born, and also the effects on the child. The psychiatrist must feel for the patient and not with her in order to maintain some form of objectivity, in an attempt to refrain from identification with the patient, and also to assess the multiplicity of factors in the conception, the pregnancy, the consequences and the attitudes of society.

Gardner (1972, p.235a) isolates three groups of women whom he considers should be referred for a psychiatric opinion:

1. The woman with organic brain disease, mentally subnormal or with a history of psychiatric treatment prior to the pregnancy.

2. The woman who has never needed referral to a psychiatrist but has, prior to the pregnancy, been treated by her general practitioner for anxiety or depression.

3. Most commonly, the woman with no previous history of mental disease, but who is distressed by the occurrence of an unwanted pregnancy. In Britain during the first year of the Abortion

Act of 1967, 82% of all abortions performed had as their reported cause either 'neurosis' or 'transient situational disturbance'.

Priest (1972) sees the role of the psychiatrist as helping the individual to resolve ambivalent feelings, but eventually a decision has to be made and the question arises as to who is best capable of doing so. In the United States and Sweden, committees or boards are established consisting of a gynaecologist, psychiatrist, social worker and other senior specialists, and a joint decision is made. Some individuals do not wish to make the decision for religious, moral or ethical reasons. For these the conscience clause, both in the British Act and the South African Act, offered a way out. Other psychiatrists may be willing to give an opinion, but do not wish to make the final decision. In other situations, as in South Africa, the psychiatrist is named as one of the decision makers along with a further two medical practitioners, and approval of the medical superintendent of the hospital where the abortion is to be performed is necessary.

Just as the psychiatrist brings to the interview his own thoughts and feelings about abortion, so does the patient. It therefore becomes obvious that each individual, through circumstances, is unique and each situation is unique. Thus, the psychiatrist cannot state dogmatic criteria for therapeutic abortion. The psychiatrist is essentially a medical practitioner who sees his patients as a whole, in terms of spirit, mind and body, and in relation to her environment. His basic task is to alleviate human suffering, both mental and physical. However, in terms of therapeutic abortion, he is only permitted to practise his art in terms of the legislation.

Hordern (1971, p.81) lists factors which may bias the psychiatrist's opinion in either recommending or not recommending a therapeutic abortion. Factors which influence a positive decision include age, pregnancy from rape or against the

woman's will, pregnancy of a woman from his own social background, or pressure from professional colleagues. Hordern (1971, p.81) also postulates that factors which might influence a negative decision may include an hysterical, demanding woman, an unmarried state, or 'blackmail' through threats of suicide or recourse to a 'backstreet' abortion; also religious, philosophical or legislative scruples in the doctor; and a history suggesting that requests for termination would recur.

In 1968, the Committee on Therapeutic Abortion of the British Medical Association published a general guide to the state of current medical opinion. It stressed that there were few medical conditions which comprised automatic indications for termination of pregnancy, and it emphasized that the decision of whether to terminate or not had to be made in the light of the circumstances of each particular case; account being taken of the woman's total environment at presentation and in the foreseeable future (Hordern, 1971). It cited a number of psychiatric illnesses to be taken note of - reactive depression, anxiety states, endogenous depression, obsessional states, hysteria, schizophrenia and mental subnormality.

Senay (1970) discusses the role of the psychiatrist. He feels that this is always to further the just interests of the patient and to unite his energies with those of the patient in order to make the best medical-psychologic judgments, and to implement them. He further states that if "the implementation of his judgments brings him into conflict with the state, he must be prepared to accept the consequences for he should become an advocate for the patient and thus play an entirely proper role in bringing about political and social conditions under which his patient can thrive" (Senay, 1970, p.412).

Peck (1968) sees the role of the psychiatrist as being essentially consultative as opposed to investigative.

Previous studies have shown that the majority of patients aborted on psychiatric grounds may never have seen a psychiatrist

previously.

Since the inception of liberalized abortion laws in Europe and the United States, indications are moving away from psychiatric grounds to medico-social grounds. Psychiatrists are involved when legislation about 'mental health and continuing pregnancy' requires their intervention.

Abortion Counselling

Abortion counselling involves both pre- and post-operative counselling. The conventional approach to counselling is a one-to-one interview. However, some abortion counselling is done in groups, which has been found to have specific advantages. The abortion counsellor may be an obstetrician, psychiatrist, social worker or nurse. In the framework of abortion on demand, counselling seeks to clarify with the patient what is best for her and what she really wants. It has been found that some women present for abortion counselling when basically they do not wish to have an abortion and are ambivalent about the situation; others are being pressurized by outside people. In the framework of stricter legislation, it is not always possible to operate in this way. It can instead become more of a question as to whether the patients fits the legal requirements or not. "An unbiased, clear account of the patient's situation, as well as counselling, can take place only when she is assured that abortion is available on request, without legal or psychiatric qualifications" (Margolis, 1971, p.1255). Most women hide their true feelings and set their mind on abortion. They do not dare express any ambivalence in case they jeopardize their chances of obtaining an abortion.

One of the major needs of women with unwanted pregnancies is for adequate counselling which will provide an opportunity for information and explanation, and for the discussion of difficulties and anxieties in an informal and unhurried way. Many women do not have this opportunity. Some feel that they have been hurried into an operation about which they had doubts; conversely others feel resentful about failures to

take account of their wishes and needs and complain of brusque, unsympathetic reactions to their predicament (Cheetham, 1974). Even at the cost of a few days delay, a decision about abortion should not be made until any problems or conflicts have been explored with the woman, and if appropriate and she is willing, with her partner or close relatives. General practitioners are in a particularly good position to give the appropriate counselling if they are so inclined, as they invariably see the woman first. Social workers are well placed to cope with both the practical and emotional needs of women with unwanted pregnancies, and could provide the medical practitioner with much needed information on which to base decisions about therapeutic abortion. The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.72) recommended wider use of social work skills in this field and more of a team approach with the gynaecologist and/or psychiatrist. In practical terms, however, it should be remembered that the counsellor has to operate within a realistic time limit, which depends on the stage of pregnancy and the waiting list for hospital beds.

Not every woman needs lengthy counselling. Bragonier and Ford (1972, p.1264) divide those who do and those who do not need psychiatric counselling into three categories:

1. Women who do not usually need psychiatric consultation:

    (a) 'Tired mothers'.
    (b) Women with character disorders.
    (c) Women with contraceptive failure.
    (d) Women with religious or moral conflicts.

2. Women who may require psychiatric consultation:

    (a) Hysterics.
    (b) Women who do not truly want an abortion.
    (c) Women in life crises.
    (d) 'Nice girls'.

3. Women who always require psychiatric consultation:

(a) Women with psychoses or history of psychoses.

(b) Women with severe depression or refactory suicidal ideation.

The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.72) lists the following women who might be referred for psychiatric assessment:

1. "Those who show symptoms of a readily certifiable mental illness and particularly where the onset of these symptoms has antedated the pregnancy.
2. Those who have a history of previous mental illness.
3. Those who are mentally handicapped (subnormal or defective).
4. Those who have a history of seriously aggressive, irresponsible or hysterical behaviour.
5. Those with prominent obsessional traits and doubts.
6. Young women who have previously had an abortion.
7. Those who are dependent on drugs or alcohol."

The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.72) further lists the following women, whom they feel need more specific social work investigation:

1. "Young adolescents, particularly those who are still at school.
2. Girls from broken homes.
3. Those with a history of marked temperamental instability indicated by poor work record and previous referral for social help or supervision.
4. Those who have previously had an induced abortion.
5. The socially handicapped and isolated.
6. Mothers who have had a handicapped or subnormal child.
7. Mothers who have already had as many children as they can support."

Abortion counselling is unique in that it also provides the opportunity for a woman to spend an adequate amount of time to clarify and determine the alternatives available to her for this pregnancy, especially if abortion is refused (Burnhill, 1975).

It is important that the woman should understand the circumstances of her pregnancy. Comaroff (1975, p.18) states that "unwanted pregnancies do not necessarily result because of ignorance of contraception, but are often subconsciously planned in the hope of coping with some personal problem. Ambivalence results because although the pregnancy is rejected, becoming pregnant represented a wish fulfilment." Therapeutic abortion in such cases may only compound a problem and result in repeat pregnancies.

Comaroff (1975, p.16) further isolates a number of reasons why one particular woman requests therapeutic abortion while another with an unwanted pregnancy will accept the issue and go through to term.

1. Confrontation with reality, e,g, desertion of the reputed father, lack of financial resources, etc.
2. Compliance with the wish of others, e.g. parents, reputed fathers, may be pushing for the abortion.
3. Dependency needs, e.g. some women cannot tolerate the idea of the baby's total dependency on them.
4. Confirmation of the right to continue with the pregnancy, e.g. an engaged couple not planning to marry immediately may wish to be reassured that they may have the baby.
5. A call for help with other problems, e.g. the pregnancy has become the last straw and there are more pressing underlying problems.

Numerous reasons are given for requesting an abortion - the stigma of illegitimacy, resistance to raising a child, feeling either too old or too young to have a baby, those whose careers are in jeopardy, threatened rejection by the

family, desertion of the reputed father and severe family pathology. These reasons are expressed consciously and overtly. Bragonier and Ford (1971) in the United States outline areas which need to be explored carefully in pre-abortion counselling.

1. What are the overt reasons for needing an abortion? What alternatives have been considered? Are there moral or religious conflicts?
2. What is the woman's experience with prior pregnancies (or abortion)? Has she had adverse sequelae, e.g. post partum depression?
3. What methods of contraception has she used? Is there misunderstanding of techniques on her part or ambivalent motivation?
4. Has she suffered any losses lately (e.g. death, broken interpersonal relationships)? Is the pregnancy an unconscious attempt to replace such a loss or manipulate a relationship?
5. Are there symptoms of emotional distress, e.g. insomnia, anorexia, nightmares, phobias, etc. and when did these begin?
6. Is there suicidal ideation and if so, does it persist after the offer of an abortion?
7. What are the woman's plans after the abortion?

In England, Newton et al (1973, p.1841) have defined two groups of women who need abortion counselling from the general practitioner. Firstly, where the patient is certain in her own mind that the pregnancy is unwanted and is not afraid to seek advice. Secondly, where the patient is frightened, may not be certain that she is pregnant and is shy about contacting her doctor. It is important at this stage for the doctor to get as complete a picture as possible of the woman, her situation and her reaction both to abortion and to the alternatives, and then refer the woman to the

appropriate specialist if necessary.

The woman needing most counselling is the one who is in conflict about her pregnancy - whether to seek an abortion or to go through to term. Such conflicts may be expressed verbally or non-verbally; it is useful to obtain a detailed description of the discovery of the pregnancy, its impact on the woman and with whom and when it was discussed. Quite often women in conflict over a pregnancy will deny its existence even up to advanced stages. The purpose of the pregnancy should be differentiated from the meaning of having a baby. Ultimately once a medical decision is reached, this should be discussed thoroughly with the woman - her reactions and how she will cope either with a therapeutic abortion or going through to term.

Also in the United States, Friedman (1973, p.13) isolates three goals in psychiatric consultation prior to abortion:

1. To determine the extent of the woman's ambivalence, to uncover her unconscious motivation or conflicts and with this clarified, help the woman in making a decision.
2. To evaluate the woman's coping capacity.
3. To assess the quality of life that would be available to the infant.

She further discusses ambivalence to pregnancy found in women in different life situations - women in a stable marriage, women in troubled marriages, illegitimate pregnancy featuring a relationship with the man and illegitimacy with no relationship with the man. She emphasizes that the presence of ambivalence has to be individualized according to the life situation of the woman.

Follow-up counselling, whether the pregnancy is terminated or not, is thought necessary for some patients. However, there is a tendency for more of those women whose pregnancies were terminated than those not terminated, to attend. Many do not attend due to not having established an ongoing

relationship with the counsellor. A number of those whose pregnancies are not terminated will also seek and succeed in obtaining illegal abortions, which they do not wish to divulge.

Abortion counselling may be carried out in a group situation. It is thought that some patients feel more comfortable in discussing abortion with other women in the same situation. To a large extent, conflict over pregnancy and abortion is engendered by group processes, e,g, the family, community, social class (Smith et al, 1971). Therefore it may be seen as appropriate for these conflicts to be expressed and resolved in a group situation. Also, there is the practical advantage of assisting more women in the same amount of time. The group situation gives the woman support and also provides an opportunity for the counsellor not only to help in the resolving of conflicts, but in preparing the women for the abortion operation and subsequent contraceptive advice.

Bracken et al (1973) conducted a study comparing the reactions of women to abortion counselling in the group situation with abortion counselling on a one-to-one basis. It was found that most women preferred individual counselling. Responses to the abortion procedure were more positive among women over 20 years of age who had individual counselling. Younger women responded to the abortion more favourably after experiencing group counselling.

Burnell et al (1972) report their findings on the use of group therapy after therapeutic abortion. They concluded that the program was beneficial, helping the women to cope with guilt feelings and to clear up misinformation about sexual matters, including contraception.

<u>Psychiatric Indications for Therapeutic Abortion</u>

It is important in the abortion decision to distinguish between normal reactions to a pregnancy, whether wanted or not, and abnormal reactions. Pregnancy causes both emotional and physiological stress. It will affect a woman's attitude towards herself, her body, her partner and her other children.

Her response will also be influenced by those around her - the reaction of her partner, relatives, friends and her life situation. "Pregnancy represents a personal crisis for the woman, bringing about a special interaction of mind and body, self and society (Callahan, 1973, p.52). "Pregnancy disrupts the existing homeostasis, necessitating changes in an attempt to achieve a new adaptive balance" (Babikian in Friedman et al, 1975, p.1498).

The first trimester is characterized by ambivalence, no matter how planned and desired the conception was. Dormant unconscious fears and conflicts are activated. The outcome of these conflicts will be determined by the mental health of the woman and the support, or lack of it, from her environment. With the onset of 'quickening', the pregnancy becomes a reality. At this point the woman usually accepts the pregnancy, particularly when it has been planned. However, refusal to accept the pregnancy may occur where the pregnancy is not desired. This may result in denial of the pregnancy, psychosomatic ailments or efforts at aborting the foetus. During the second and third trimesters the foetus becomes a 'baby' and an accepted reality (Babikian in Friedman et al, 1975). In considering abortion, it is most important that the psychiatrist be aware of the conflict which the woman experiences during the early stages of pregnancy. He must continually ask himself or postulate how the woman will react in the long run to either abortion or continuation of the pregnancy through to term.

The motivations for seeking an abortion are many and varied. They may originate in her unconscious and reflect her ambivalence to the state of pregnancy itself, or may activate other conflicts or arise out of sheer economic necessity.

The legality or illegality, plus the controversial nature of the subject of abortion, has led to a voluminous amount of confusing literature on psychiatric indications and criteria for therapeutic abortion. This has increased due to the non-specifity of the laws. Psychiatric indications are

frequently included in the clauses relating to preservation of 'the life and health of the woman'. Various interpretations of the law are made and there is little consistency in opinions expressed. Likewise with such terms as 'normalcy', no consistent definition exists, although many use as their guideline the definition of 'health' as formulated by the World Health Organisation - 'a state of physical, mental and emotional wellbeing' (Callahan, 1973, p.50).

Although specific psychiatric indications for therapeutic abortion are not legally codified in most countries, a number of authors and committees have attempted to lay down criteria on which to base an opinion. Simon (1964, p.71) enumerated eight factors which he felt should be considered in the abortion decision:

1. The danger of the exacerbation of an existing psychosis or the precipitating of one, including post-partum psychosis.
2. The exacerbation or precipitating of a serious neurosis.
3. The number of children the woman already has and her serious wish regarding the pregnancy.
4. The threat of suicide with depression.
5. The family situation and relationships.
6. Mental retardation.
7. The woman's socio-economic state.
8. Foetal indications.

There are three other specific areas in which indications may be considered more clearly justifiable - rape, incest and pregnancy in the presence of severe physical illness.

In 1968 the British Medical Association Committee on Therapeutic Abortion attempted to enumerate specific psychiatric illnesses which could be considered indications for termination of pregnancy. The following were the psychiatric conditions listed (Report by B.M.A. Committee on Therapeutic

Abortion, 1968, p.174):

1. Reactive depression.
2. Anxiety states.
3. Endogenous depression.
4. Obsessional states.
5. Hysteria.
6. Schizophrenic states.
7. Mental subnormality.

"Generally it can be stated that therapeutic abortion should be considered when the history and examination provide strong reason to believe that the pregnancy, if allowed to continue, or the delivery, would result in serious psychiatric illness or would seriously impair the recovery of an already ill woman" (Kummer *in* Hall, Vol. I, 1970, p.102). Kummer goes on to isolate five criteria of serious illness:

1. The possibility of the patient harming herself or others, particularly the newborn.
2. The problems related to management (hospitalization, restraint, supervision, care of the newborn, etc.).
3. Extremes in anguish as seen in obsessive-compulsive neuroses.
4. The length of the illness and its reversability, either spontaneously or with treatment.
5. The effect on the child through heredity and environment.

Pfeiffer (1970) attempts to distinguish between psychiatric indications, the 'hard' criteria, and psychiatric justifications, the 'soft' criteria. In the former are women who are experiencing psychiatric symptoms that would warrant psychiatric attention, whether or not these women were seeking an abortion. In the latter are women who seek

psychiatric consultation only because they wish to obtain a legal abortion. Additional treatment is not indicated in these cases. Pfeiffer (1970) includes under psychiatric indications active psychoses, serious suicidal risk and severe personality disorders. Among psychiatric justifications he includes temporary emotional turmoil related to the unwanted pregnancy, the likelihood of upsetting career or marriage plans, economic hardships, family pressures, etc. "In these latter situations it becomes increasingly difficult to separate psychiatric justification from abortion on demand" (Pfeiffer, 1970, p.404).

Sim (1968, p.895) takes a firm stand in stating that "there are no psychiatric indications for termination of pregnancy." He sees the abortion problem as in no way preventing mental illness, but instead it may be a precipitant. He considers that it is no cure for psychiatric illness, that it is a socio-economic problem and as such, the psychiatrist should stick to clinical facts in his practice of medicine.

Gardner (1972, p.246a) isolates two primary questions which should be asked when assessing a woman for therapeutic abortion. Firstly, what is the woman's total situation? This requires estimating her environment and family. Secondly, what are the risks of an abortion to this particular woman? This includes the physical risk of the woman's ability in the future to bear children, and the emotional risks of either abortion or continuation of the pregnancy.

It should be noted that a request for a therapeutic abortion produces a strained psychiatrist/patient relationship in that the woman's motive is to present herself in such a way as to gain an abortion. Her greatest need is to convince the psychiatrist of her inability to continue with the pregnancy. She knows the psychiatrist is able to give her what she wants. This leads to the patient attempting to manipulate the medical practitioner. The psychiatrist resents such manipulation. The normal motivation which promotes co-operation is absent and a strained relationship exists between the woman and the psychiatrist.

In many instances the woman may attempt to manipulate the psychiatrist by threats of suicide or illegal abortion. In most cases of recommendation for therapeutic abortion, the indication given is that of risk of suicide. This is a matter of predictive clinical judgment (Fleck, 1970). There is divided opinion as to the likelihood of suicide in women with unwanted pregnancies. Sim (1968) maintains that suicide is less frequent in pregnant than in non-pregnant females and that suicide rates are low in the entire female population during the childbearing years. Other clinical experience suggests that suicide is equally frequent in pregnant and non-pregnant females and is by no means as rare as to be irrelevant (Senay, 1970). Senay (1970, p.411) makes the point that a psychiatrist should consider each patient in her own right, should not generalize, and must assume that people who think of suicide are at risk. Although infrequent, suicide attempts during pregnancy do occur, and therefore threats should be noted carefully. Marder (1970, p.1232) cites the following criteria for establishing the severity of suicidal indication:

1. Slight - a history of previous suicide attempt or the patient is more than mildly depressed.
2. Moderate - a history of multiple suicide attempts without major improvement in the life situation or demonstrable intrapsychic changes or if there is a new stressful situation (e.g. unwanted pregnancy).
3. Severe - a history of multiple suicide attempts and a recent major setback, or history of having made a near-fatal suicide attempt, and current preoccupation with suicide.

Rosenberg and Silver (1965) conducted a study of suicide risk in women seen by psychiatrists for therapeutic abortion. Their study showed that the incidence of suicide attempts in pregnant women is approximately one-sixth that of the rate for non-pregnant women in a comparable age group. From this they postulate that pregnancy may have a psychically protective

role. However, the general impression gained from the study was that patients seemed to manage after the pregnancy, regardless of outcome, much as they had before the pregnancy.

A prior history of psychiatric illness is frequently taken as a guideline in the therapeutic abortion decision, but as stated earlier, some authors maintain that these women are least likely to cope with an abortion. However, a study by Ewing and Rouse (1973) showed that in a follow-up study of 126 women who had a therapeutic abortion on psychiatric grounds, 52 women with a prior history of psychiatric disturbance did not experience significantly more post-abortion emotional reactions by comparison with the others. 96% of the psychiatric group and 92% of the controls reported that their emotional health was better or normal afterwards.

Psychiatric Sequelae of Therapeutic Abortion

There are marked differences of opinion among psychiatrists about many aspects of abortion, particularly the sequelae of abortion. These opinions may be partly based upon differing moral and philosophical ideas, but also from each psychiatrist's different personal clinical experience with therapeutic abortion and his interpretation of the literature on the subject. The psychiatric literature also reflects varied opinions. In examining the consequences of abortion, three aspects must be considered:

1. Immediate psychological effects on the woman of induced abortion.
2. Long-term psychological effects of induced abortion.
3. Long-term psychological effects on unwanted children born to women denied a therapeutic abortion.

I shall consider aspects 1 and 2 first.

Most women who become unwillingly pregnant suffer some form of emotional reaction such as anxiety, depression, distress, anger, etc. In only a few cases does the response amount to actual mental illness. Where mental disturbance is marked however, some disturbance has been present to some degree prior

to the pregnancy (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.53).

Woods (1975, p.83) states that "the woman who finds herself pregnant and decides to terminate the pregnancy is already in a potentially traumatic situation." In deciding to seek an abortion and accept the consequences, four traumatic events will occur (Woods, 1975, p.83):

1. The woman must accept that she is pregnant with an unwanted pregnancy.
2. The woman has to accept the procedure laid down for assessment for therapeutic abortion.
3. The woman has to experience the actual abortion.
4. The woman must accept the decision and its later consequences.

A number of factors will influence the woman's reaction to therapeutic abortion - her religious background, social pressures, support from family members and the reputed father, her ambivalence prior to the operation, the abortion procedure itself and the attitude of staff members towards her. Any one of these may contribute to feelings of guilt post-operatively, or to the woman being able to accept the abortion. However, it is generally believed that the psychological sequelae of abortion are short-lived and tend to reflect the circumstances surrounding the abortion and the attitudes conveyed by significant others in the peer group, family and health care setting (Woods, 1975). Another important factor contributing to the woman's reaction to abortion is her psychological state prior to the pregnancy. Many women find the process of assessment prior to the decision being made more traumatic than the actual operation and relief appears to be the predominant post-operative reaction.

The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.55) made the following generalizations about the relationship between mental health and therapeutic abortion:

1. "The great majority of abortions are now carried out on psychological or psycho-social grounds.

2. A very small minority of those who are therapeutically aborted are seriously mentally ill.

3. Therapeutic abortion has little influence, for good or ill, upon the course of an existing serious mental illness (e.g. schizophrenia).

4. Therapeutic abortion has serious mental sequelae in perhaps 2% of cases.

5. In those who are temporarily unstable, continuation of an unwanted pregnancy is no more likely to have adverse effects than is therapeutic abortion.

6. To those distressed by an unwanted pregnancy (suffering from a 'reactive depression') abortion usually brings quick, substantial and lasting relief. Feelings of regret, self-reproach and guilt have been found to be present in about 20% of cases, but it appears that such feelings are usually mild and transient.

7. Emotional distress is more likely in late abortions, after foetal movements have been felt and maternal feelings have been aroused. Operative procedures (e.g. saline induction) which involve miniature labour are more likely than are other techniques to cause such distress. The emotional distress suffered by nurses assisting at such miniature labour may be communicated to the patient.

8. Significant psychiatric sequelae of abortion are more likely in those who have been temporarily unstable prior to the pregnancy. The clearer the psychiatric indications are for abortion, the more probable it is that psychiatric disturbance will also occur after the

abortion. This disturbance may or may not be related to the abortion itself."

Ignorance of the outcome of abortion arises from the failure to differentiate between the following factors (Gardner, 1972a). The risk of observer bias in the investigation, and also the difficulty of finding out the woman's real feelings after the operation - she may suppress her feelings of guilt in order to prove that she could cope with an abortion but could not have coped with a continuation of the pregnancy. In the past three decades, there has been a deluge of psychiatric literature on the after effects of therapeutic abortion with results ranging from severe-to-moderate-to-mild-to-no guilt or remorse. However, in the past decade reports indicate that therapeutic abortion seldom induces severe negative reactions.

Between 1940 and 1959, reports emphasized the damaging after effects of therapeutic abortion. To quote: "There were many statements regarding the desire for motherhood and the rage and despair that results from its curtailment" (Friedman et al, 1974, p.1332). From about 1960 different views emerged and various studies reported that negative reactions diminished in the course of time; also in the majority of instances, whatever guilt existed did not give rise to psychiatric illness nor to longlasting regret. In some instances abortion was seen as genuinely therapeutic (Friedman et al, 1974).

Wilson and Caine, as reported by Simon and Senturia (1966), studied 226 women who had undergone therapeutic abortion during the period 1930-1949. Follow-up questionnaires were sent to 79 of these cases and nine of the women were interviewed. No valid information could be gathered from the questionnaires. However, six of the nine women interviewed had symptoms related to the abortion, but three voiced no such complaints. Two of the six women still felt a sense of loss and guilt. The four others complained of psychosomatic symptoms. The authors concluded from this very small sample that abortion, whether induced or spontaneous, could cause deep and lasting effects. In a further study in 1952 on 25

women who had had either spontaneous, legal or illegal abortions, Wilson recorded changes in the attitude of women towards their sexual partners, and to spontaneous, legal or criminal abortion. He was of the opinion that this was noteworthy as it could cause much unhappiness in the home. In 1954 Dunbar (Simon and Senturia, 1966) concluded that whatever the motive for abortion, the operation arouses an unconscious sense of guilt in all patients who either voluntarily or involuntarily have an abortion.

Perhaps the best documented study on the after effects of therapeutic abortion was conducted by Ekblad in Sweden and published in 1955. It is the most quoted study to support arguments both for and against therapeutic abortion. He studied 479 Swedish women who had undergone legal abortion during the period 1949-1950. All of the women were interviewed shortly after the operation and again two to three years later. 58% of these women had had symptoms of chronic neurosis and abnormal personality prior to the aborted pregnancy. Also in the group were a large number of women with disturbed marriages, 27% of the sample were unmarried, several of whom had a disturbed relationship with the father of the child. Ekblad found at follow-up that 65% of the women stated that they were satisfied with their abortion and had no guilt feelings or feelings of self-reproach; 10% had no self-reproach but felt the operation itself was unpleasant; 14% had a mild degree of self-reproach and 11% regretted the operation and felt very guilty about it. Ekblad also found that guilt was greatest in those women who had been influenced by others in the abortion decision and least in those women who had opted for the operation themselves. Of the 11% who stated that they had severe guilt feelings about the operation, Ekblad found that from a psychiatric point of view, the reactions were mild, and only 1% had their work ability affected. A correlation between the severity of guilt and degree of psychiatric disturbance prior to the abortion was found. A paradox was pointed out - that the greater the psychiatric indications for therapeutic abortion, the greater

the risk of adverse reactions to the abortion. A further Swedish study was conducted by Malmfors (Simon and Senturia, 1958). He studied 84 women who had had legal abortions and found that 37% admitted guilt feelings. Ten of the sample of 84 were classified as having suffered impairment of mental health.

In Japan, where abortion is permitted on extensive social grounds since the Eugenic Protection Act of 1960, a relatively high incidence of guilt is reported. In 1965 the Mainichi Survey of 3600 married women found that 18% had no remorse or guilt feelings, 28% felt that they had done something wrong, 35% felt sorry for the foetus, 4,5% had fears of sterility, 6,5% had a variety of responses and 8% did not reply to the research questionnaire. Babikian (<u>in</u> Friedman et al, 1975, p.1499) concludes that 80% of these women felt some degree of guilt.

In 1966, Peck and Marcus reported a study they had conducted in the United States on 50 women, half of whom were aborted on psychiatric indications and half for non-psychiatric reasons. The two groups were matched for age, race, parity, marital status, as well as economic and educational level. The psychiatric status of 92% of the total sample was found to be unchanged at follow-up three to six months after the operation. In the psychiatric group 12% (3) reported mild guilt, 12% (3) moderate guilt and 4% (1) severe guilt. In the non-psychiatric group, reactions were milder with 28% (7) reporting mild guilt, 8% (2) moderate guilt and none had severe guilt. Mild guilt occurred in 20% of the total sample and 98% stated that they would elect to have a further abortion if it proved necessary. All 25 of the women in the psychiatric group were considered to be psychiatrically ill at the abortion assessment, but only eight were still in treatment at the time of follow-up. The authors make the inference that abortion might be as therapeutic as psychotherapy.

Patt et al (1969) in the United States gathered follow-up

data on 35 women who had had a therapeutic abortion on psychiatric grounds during the period 1964-1968. Short-term effects were considered by the authors to be good in 20 of the cases. The remaining 15 felt some degree of guilt or remorse for a period of two to six months after the operation. Long-term effects after a period of two to four years after the operation showed that three-quarters of the women reported improved emotional status, and psychiatric histories confirmed this. Two of the patients, each of whom reported having been pressurized into requesting the operation, experienced prolonged guilt feelings. Twelve patients experienced conscious guilt, but only two would not have the abortion again. Eight patients reported that the abortion had led to emotional growth.

Perez-Reyes and Falk (1973) in the United States conducted a follow-up study of 41 adolescents six months after therapeutic abortion. The intensity of feelings of guilt, anger and depression were confined to the immediate post-operative period. The most favourable outcome was correlated with support from parents, hospital personnel and society in general and was also related to whether or not the patient had made the decision herself. It was also found that the abortion experience could become a source of emotional growth if those around the girl had a positive and non-punitive attitude.

Bracken et al (1974) also correlate positive outcome with the presence of support in the abortion decision. In a study of 489 women in the United States, partner support was found to be significant in the older married women, while parental support was significant in the younger single women.

Friedman et al (1974, p.1334) postulate that from their experience of women undergoing abortion on psychiatric grounds, three hypotheses may be isolated in relation to the abortion decision:

1. Women who make relatively conflict free decisions feel relieved after abortion.

2. Women who see the foetus as a baby feel guilty

or sad in the post-partum period.

3. A woman's style of coping with abortion is consistent with her general coping style.

It may be concluded from the above-mentioned research that studies of therapeutic abortion show few negative sequelae, that even among women with serious psychiatric problems, the data indicates few psychological complications resulting from abortion, and lastly, abortion could be considered genuinely therapeutic, primarily having a positive effect on the woman's psychological status (Orsofsky et al, 1975).

Consequences of Refused Therapeutic Abortion and Alternatives to Therapeutic Abortion

There is scant literature on the follow-up of those women who are denied therapeutic abortion. The main reason for this is probably the hostility felt by these women towards those who have denied them a legal abortion.

A number of alternatives exist to therapeutic abortion. Illegal abortion may be sought and obtained. The woman may threaten or attempt suicide, or she may go through to term, accepting or rejecting the infant. The woman may get married to the reputed father or she may keep and rear the baby alone, or have it adopted or fostered.

Meyerowitz et al (1971) in the United States, conducted a follow-up study of women aborted legally and of those refused abortion. They found that while social class did not influence the recommending or carrying out of an abortion operation, of the women who were refused abortion, those with higher social status were more likely to obtain abortion elsewhere. This discrepancy between the social classes has been discussed earlier. There are no accurate statistics that reflect the number of women who abort spontaneously after the refusal of a therapeutic abortion, or who later gain an abortion on medical grounds, or even obtain illegal abortions. However, the Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.56) estimated that at least 30% of those at first refused may eventually obtain

an abortion, and a substantial proportion of these (approximately one-fifth) do so within the National Health Service.

Psychological effects of refused abortion vary considerably. Some women are grateful to have been refused as they have actually presented themselves for assessment for therapeutic abortion in order to resolve their own ambivalence about the pregnancy. These women may feel relief and even a release from guilt feelings associated with having attempted to obtain an abortion. However, probably in the majority of such women disappointment, frustration, anxiety and depression may be present to varying degrees and for varying lengths of time prior to the birth. As mentioned before, the first trimester is usually the period when the most adverse reactions occur. After 'quickening', with arousal of maternal instincts, the pregnancy becomes more of a reality and some women find it easier to come to terms with the situation.

Two generalizations regarding the effect of refused abortion are current. Firstly, that significant psychiatric sequelae, both after the abortion and where abortion has been denied, are more likely in those who have been temporarily unstable prior to the pregnancy; and secondly, in these, the continuation of an unwanted pregnancy is more likely to have adverse effects than is the therapeutic abortion (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.158).

Pare and Raven (1970) studied 321 women in England referred for therapeutic abortion. Both those recommended and those not recommended who were traceable were followed up one to three years later. The authors found that continuation of the pregnancy did on occasion lead to psychiatric disability. One-third of those who kept their babies showed evidence of resentment and regretted not having had an abortion. In the group who were refused therapeutic abortion, 61 patients were followed up, 38% had an abortion elsewhere. Of those who continued the pregnancy, 16% had the baby fostered or adopted, and two-thirds of the women who were married accepted their babies.

It should be noted that an unwanted pregnancy does not necessarily lead to an unwanted child. Some mothers, both married and single, react favourably to the situation. Married women and women who have a stable relationship with the father are more likely to accept a previously unwanted child than the women who is neither emotionally or physically supported. Evidence suggests that inside marriage the majority of unplanned pregnancies are normally accepted and the children integrated into the family (Report of the Working Party of the Royal College of Obstetricians and Gynaecologists, 1972, p.23).

One of the most thorough and most often quoted studies on the outcome of children born after abortion was refused was conducted by Forssman and Thuwe in Sweden and was published in 1966. They investigated the mental health, social adjustment and educational level of 120 such children up to the age of 21 years. A control series was matched with this group. By the age of 21 years, the unwanted children had received more psychiatric care, exhibited more anti-social and criminal behaviour and had received more public assistance than the control group. The differences in the two groups was statistically significant and the authors concluded that the child born to a woman who had requested an abortion started life at a disadvantage and had to surmount greater social and mental handicaps than his peers. These findings were tabulated as follows:

	Unwanted Children	Control Group
Illegitimacy	27%	8%
Adoption	7%	0%
Insecure childhood	54%	22%
Psychiatric care in childhood	28%	15%
Delinquent	18%	8%
Public assistance (18-21yrs)	14%	3%
Higher education	14%	33%
No defect	48%	68%

The 'battered baby' syndrome is sometimes quoted as an outcome of refused abortion. The Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.62) stated that, "We know of several cases where the mother of a 'battered baby' had tried and failed to obtain an abortion but we do not know the proportion which such mothers bear to the whole number of the mothers of these unfortunate children." The Commission considered that there was not enough evidence in this area for it to recommend an amendment to the British Abortion Act, but advised that special care should be given to such women when being assessed for therapeutic abortion.

Turning to the problem of the unmarried mother, she has a number of alternatives which she may consider - to marry and keep the baby, to have the baby adopted or fostered, or to keep and rear the baby alone without getting married.

Marriage is considered the obvious alternative for those already planning to get married. Abortion, if carried out, could in fact be detrimental to the impending marriage, particularly if the woman subsequently finds herself unable to conceive. However, marriage for those who have not already considered it, may not be considered in such a positive light. The figures for America, where the present divorce rate is 1 in 4, show that teenage marriages with premarital conception have a divorce rate three to four times as high as that of marriage over the age of 20 years (Gardner 1972, p.174a).

Adoption or fostering may be considered by the expectant unmarried mother. As at present practised in most countries, adoption involves giving up the baby totally to an unknown family selected by an adoption agency. This procedure has both positive and negative aspects. From the positive point of view, it allows the woman to start again with a clean 'slate' and gives the baby the opportunity of being accepted by an established family to whom this is a welcome addition. However, the unfavourable aspect of adoption should also be

considered. As practised now, it can be viewed as a heartless procedure. The woman undergoes a mourning process at the loss of her baby without the social support she would have received if the baby had been born within a marriage and had then died. Fostering is a further alternative but has a number of disadvantages. It involves placing the baby in the care of another family who are expected to meet his day to day requirements while the biological mother has the option of reclaiming the baby. The foster mother is often reluctant to get emotionally involved with the child, nor can the biological mother who is seldom physically present to establish a relationship with the child.

Keeping the baby is a further alternative. This seems appropriate where the woman particularly wants to keep the baby and is able to encorporate him into her own family situation, where she may receive support. However, it can be unrealistic and lead to a later separation, which can prove to be more traumatic for both the mother and the baby, when the woman is young and has to struggle alone. She may only realize her inability to cope with the baby financially and emotionally after having tried for a number of months. In Britain about 60% of babies who are adopted have been fostered out before being placed with adoptive parents (Hordern, 1971, p.61).

It is useful to compare women who have been legally aborted and those who have gone through to term and had their babies adopted. A study by Burnell et al in 1973 as reported by Osofsky et al (1975) is of particular note with regard to this. The investigators studied the difference at follow-up of a group of women who had undergone therapeutic abortion, a group of apparently normal pregnancies and a group of women who had had their babies adopted. They found that all of the groups experienced some psychological problems during the pregnancy, with those of the abortion and adoption groups being more severe than the normal pregnancy group. However, the abortion group coped better than the adoption group. 25% of the abortion group and almost none of the adoption

group reported improved adjustment; 20% of the adoption group and almost none of the abortion group reported worsened adjustment, and those who placed their babies for adoption felt much more negative about their experience than did the women who underwent abortion.

Further Studies on Therapeutic Abortion

In 1966 Simon and Senturia published an article reviewing the literature on the psychiatric sequelae of abortion from 1935-1964. The conclusions drawn from this review are:

1. That personally deeply held convictions frequently outweighed the importance of data.
2. The findings on the sequelae of therapeutic abortion ranged from psychiatric illness almost always being an outcome of therapeutic abortion to its virtual absence as a post-abortion complication.
3. There was a certain amount of agreement that women with diagnosed psychiatric illness prior to abortion continued to have difficulty post-operatively.
4. There was a lack of information on the long-term effects of therapeutic abortion on the individual.
5. There was little information on the subsequent pregnancies of women who had undergone therapeutic abortion.

Since this publication, a number of further studies have been conducted, some of which are briefly described here in chronological order.

As previously described, Peck and Marcus (1966) studied 50 women in the United States who had therapeutic abortions. Half of these abortions were performed on psychiatric grounds and half on other medical indications. Post-operatively guilt was present in both groups but was more marked in the psychiatric group. The authors postulated that perhaps the knowledge in the medical group that the abortion was not initiated

by them, but was made necessary by disease for which they had no responsibility, made the loss of the pregnancy easier to overcome; and greater guilt in the psychiatric group indicated that despite conscious rejection of the unwanted pregnancy, there was possibly some ambivalence about continuing to term. The authors concluded that there was no change in the basic psychiatric status of any of the women - those who were schizophrenic before remained so, as did those who were neurotic. However, "the anxieties and depressions which were the distinct consequences of the pregnancy at this time in their lives, were relieved" (Peck and Marcus, 1966, p.424).

Patt et al (1969) reported a follow-up on 35 women in the United States who had been aborted on psychiatric grounds three months to four years previously. They found that almost 50% of these women suffered prolonged, intensified or entirely new psychiatric symptoms in the two to six months after the abortion, but in most of these they considered that the symptoms were less severe than those which might have been anticipated if the pregnancy had continued. Long-term follow-up showed that one-third of the group experienced guilt feelings, but that only two of the women would not seek abortion again. The authors concluded that "many of these women derived lasting psychological improvement from the abortion in the form of decreased masochistic acting out, increased independence and initiative, or an increased trust in helping figures" (Patt et al, 1969, p.413).

Pare and Raven (1970) followed up 250 of 321 women in England from one to three years after they had been referred for psychiatric opinion for therapeutic abortion. In those (130 patients) who had had an abortion, the authors report that little psychiatric disturbance had resulted, provided that the woman herself had asked for abortion. However, in those who were not recommended for therapeutic abortion (120 patients), one-third of the women who had kept their babies were rejecting them. The authors emphasized that the stress of bearing an unwanted child may lead to psychiatric symptoms and follow-up of those refused therapeutic abortion is of

extreme importance.

Meyerowitz et al (1971) studied 168 women in the United States over a seven year period who had been referred for psychiatric assessment for therapeutic abortion. Sixty of the women were not recommended. At follow-up it was found that 21 had gained abortion elsewhere and 23 carried the pregnancy to term. Eighteen of the latter were assessed at follow-up. Seventeen of these women were considered to have shown little or no distress during the pregnancy. However, one showed an adverse reaction requiring psychiatric hospitalization immediately after the birth. Follow-up data was gathered on 93 of the women who were recommended for therapeutic abortion. 64% (60 patients) of these women showed immediate relief, six showed mild guilt but did not express regret, six showed pathological mourning as a result of the loss incurred by the abortion. Three of the latter group required hospitalization after they had developed an active psychosis. Of the remaining three women who showed adverse reactions, two had intense feelings of depression post-operatively and one made a suicide attempt requiring hospitalization. Thus, most of the women of both groups were better or unchanged at follow-up. However, a small group of those aborted were considered worse and showed evidence of adverse response after the abortion.

Ford et al (1972) compared a group of 40 women in the United States requesting therapeutic abortion with a group of 52 pregnant women not seeking abortion. Those in the abortion group complained of more psychosomatic symptoms and they were more likely to have received psychiatric treatment, to have poor sexual adjustment and to reject the maternal role than those in the non-abortion group. Their MMPI scores were significantly elevated for most of the scales. Most of the abortion group had failed to use any form of contraception and as such, the authors suggest that "contraception is often related to unconscious efforts to resolve conflicts over feminine identity and that abortion is requested especially when the occurrence of pregnancy fails to resolve these

conflicts" (Ford et al, 1972, p.62). The authors suggested that the main motivating factor in requesting abortion is more the rejection of motherhood than socially conditioned responses such as guilt or shame.

Abernethy (1973) compared 65 married and single women who had had an abortion with a matched control group who appeared to be effective users of contraception. The area of the study was to identify characteristics which might be considered to constitute risk for unwanted pregnancy. It was found that role redefinition in the family of origin was one such factor. The principal components of this role redefinition were (p.346):

1. "The daughter taking over some elements of the mother's role as wife or housekeeper.
2. The daughter's alienation from the mother.
3. Intimacy between the father and daughter which excludes the mother."

Other differing characteristics between the two groups included the abortion group's dislike of sexual intercourse, but nevertheless identifying their most important relationships as having been with men, and in their own family of having had inadequate support from female friends and relatives.

Smith (1973) followed up a group of 80 women who had undergone therapeutic abortion; over a one to two year period after the operation, she found that the women exhibited little guilt or feelings of regret and concludes that "for the majority of women with unwanted pregnancies, abortion does not have grave emotional hazards" (p.584).

Lask (1975) conducted a study on 50 women undergoing therapeutic abortion in a London hospital in an attempt to isolate characteristics of those women who were particularly at risk for psychiatric sequelae of abortion. Outcome of therapeutic abortion was considered favourable when the following criteria were met (p.174):

1. "The patient expressed satisfaction with the termination and considered it to be the best solution.
2. No feelings of guilt, loss or self-reproach and if present, only mildly so.
3. No evidence of mental illness."

The outcome was considered unfavourable when:

1. "The patient regretted the termination.
2. The patient exhibited moderate or severe feelings of loss, guilt or self-reproach.
3. There was evidence of mental illness in the same degree as, or more severely than before the operation."

68% of the group met the criteria for favourable outcome with 32% not doing so. 84% of the total sample had no regrets about the termination while 16% regretted the abortion. 89% of the total sample were considered to have improved or the same psychiatric status. It was argued that in the majority of cases with an adverse reaction, this outcome was related to the woman's environment post-operatively rather than the operation itself. Factors isolated to identify the women likely to have adverse reactions included multiparity, foreign born, desertion by the partner, age groups 21-30 years, prior history of mental illness, existing psychiatric state at the time of assessment and the presence of ambivalence about abortion.

Greer et al (1976) in England studied 360 women at presentation for therapeutic abortion and followed up 326 of these women over a 15 month to two year period. "Outcome was assessed in terms of psychiatric symptoms, guilt feelings and adjustment in marital and other interpersonal relationships, sexual responsiveness and work record" (p.74). Results showed that adverse psychiatric sequelae were very rare and that compared with adjustment just prior to the operation,

significant improvement was evident at follow-up. The authors concluded that "legal abortion undertaken before the twelfth week of pregnancy by vacuum aspiration accompanied by brief counselling carried only minimal risk to untoward psychological and social sequelae up to two years afterwards. In respect of frequency and severity of psychiatric symptoms, feelings of guilt, interpersonal relations and sexual adjustment, significant improvement was evident" (p.78).

Preventive Psychiatry and Therapeutic Abortion

Abortion may be seen as a form of preventive psychiatry. Firstly, it may give immediate relief to the pregnant woman and secondly, it prevents the birth of an unwanted child. "Preventive psychiatry's single most effective tool is the prevention of unwanted offspring, and refusing an abortion to a woman who does not wish to become a mother at the particular time is forcing her to remain pregnant against her will" (Fleck, 1970, p.47).

Abortion is the most ancient and widespread form of birth control. Lebensohn (1972, p.1446) states that "legal abortion under good medical conditions should be made available to any woman as a form of family planning when other methods have failed." He maintains that legal abortion is a positive mental health measure, not only for the active treatment of the anxiety and despair of the unwilling mother, but also as an effective mental health measure to avert the consequences of unwantedness in the children and the rest of the family. In previous decades it was thought that abortion had more negative than positive psychiatric sequelae. However, recent experience has indicated that well motivated women with no previous history of psychiatric disorder emerge from a legal abortion performed under good medical conditions with no psychiatric sequelae and most women report tremendous relief (Lebensohn, 1972).

Psychiatry is also concerned with the quality of life and as such should be concerned about the effect of unwantedness

on an infant. The well controlled studies of Forssman and Thuwe, previously discussed, bear evidence of some of the sequelae to unwantedness. "The population explosion already threatens the quality of life. On the individual level, the forced arrival of an unwanted, unloved child, because of archaic abortion laws, creates grave consequences for the unwanted child, the unloving mother, the fragmented family and ultimately for society itself" (Lebensohn, 1972, p.60).

Three modern developments have put increasing pressure on the need for the reform and the liberalization of therapeutic abortion laws (Levene and Rigney, 1970):

1. Advances in medical science minimizing the risk of operative procedures.
2. The urge to control population growth.
3. The growing emphasis on individual human rights and civil liberties.

Many psychiatrists have complained that their function is to 'rubber stamp' an abortion due to the wording of the law. However, Levene and Rigney (1970) maintain that if the psychiatric profession is to function in the primary prevention of mental illness, then it must remain on the abortion scene.

Extensive family planning services, open sex education and identification of women who are at risk for unwanted pregnancy are all ways of preventing excessive use of abortion. However, as stated previously, there is no one method of birth control which is 100% effective. There is also the need to motivate the use of contraception when it is available. "The most significant barriers to the success of birth control measures are psycho-social in nature. The psychiatrist with his special insight and his training in the medical and behavioural sciences, must assume a significant role in the solution of this most critical dilemma of mankind" (Siassi, 1972, p.80). There exists the paradox that those populations who have the greatest need to make use of birth control techniques have been least receptive to such methods, e.g. India.

It would be valuable, therefore, to isolate these cultural and psycho-social aspects which mitigate against effective family planning services. Siassi (1972) reported on a six month study of 200 Iranian women taking oral contraceptives which showed only a 12% success rate among those women who themselves assumed responsibility for taking the pills, but a 93% success rate among those whose husbands dispensed the pills. The male dominance of the society contributed to the women's inability to assume responsibility for birth control.

Widespread sex education is required in schools and on campuses, but equally important is the ability to identify those women who are at risk. Abernethy and Abernethy (1974) studied the family constellation in an attempt to isolate adolescents who were at particular risk for unwanted pregnancy. A sample of 23 inpatients with ages ranging from 13 years to 20 years were studied. Each patient was assigned to either low, intermediate or high risk groups for unwanted pregnancy on the basis of past sexual experience, contraceptive use and attitude towards sexuality. It was found that low risk patients feel positively towards their mothers, whereas in the high risk groups, girls were progressively alienated from any supportive maternal figure. The feeling towards the father was exactly opposite; the warmest feelings were held by those in the high risk groups and this was related to a higher incidence of incestuous relationships. Low risk patients were stable in their feelings towards their parents. This again contrasted with the high risk groups where there was a shift between childhood to adolescence with regard to the parent towards whom they felt closest.

CHAPTER 5

THE THERAPEUTIC ABORTION SERVICE

The Department of Psychiatry at a teaching hospital in Cape Town, forecast certain difficulties in attempting to cope with the changing medical and social attitudes, as reflected by legislation, towards abortion on psychiatric grounds, and hence set up a special service to provide for this type of case. Previously these women were seen by one of a number of consultant psychiatrists in a routine psychiatric outpatient clinic.

The Procedure

From February 1974, all cases for assessment as to the advisability of recommendation for termination of pregnancy were handled in a clearly specified manner. Referrals were only accepted from full-time and part-time consultant gynaecologists attached to the hospital, and the referring consultant was requested to state in writing that he considered the patient warranted a psychiatric assessment with regard to possible therapeutic abortion and that, if as a result of the assessment termination of the pregnancy was recommended, he would be prepared to perform the operation. These patients were seen initially by a psychiatric social worker (the author). The woman was interviewed by her and a full psychosocial history was taken of the patient's past and present situation. If accompanied by her male partner or by a relative, he or she was also interviewed. The legal aspects of abortion, the patient's past and present feelings about abortion and the alternatives to abortion were discussed with her. The following morning the findings were presented to one of two senior experienced consultant psychiatrists by the psychiatric social worker and the patient was interviewed by the psychiatrist. If therapeutic abortion was recommended, the patient was referred back immediately to the Department of Obstetrics and Gynaecology in order to minimize delays. If termination was refused, she was offered further counselling.

It was considered important to maintain a consistency of opinion concerning the recommendation of therapeutic abortion and for this reason, all cases were seen by the same psychiatric social worker and the same consultant psychiatrists. If the original psychiatric social worker was away, a second one was available to collaborate with one or other of the consultant psychiatrists. It was also considered important to provide a follow-up counselling service for all patients referred. This was provided by the psychiatric social worker for both those women who were recommended and for those not recommended for therapeutic abortion.

The Interview with the Psychiatric Social Worker

At presentation, the necessity of taking a full psycho-social history, the procedure of the service and the legal situation were all explained to the patient. In the case of a very young girl, this was explained to her first and with her permission, the history was taken from an available relative , after which the present situation was discussed with both.

The format of the psycho-social history was adapted from that presented by Dr. J.L. Stricklin in 'The Psycho-Social Index' (1974). Historically the psycho-social history has been used by several behavioural sciences in attempting to understand the patient in relation to his environment. Perlman (1967, p.178) states, "The etiological diagnosis in the sense of the life history of a person or a problem may contribute to understanding the nature of the problem to be dealt with, the person who has that problem, and the ways and means that can be anticipated as helpful." Eaton and Peterson (1969) in discussing the psycho-social history, state that it may be looked at in two ways. Firstly, the interviewer may follow a chronological approach to the person's life or secondly, the interviewer may review the history by areas of life experience. However, "psychiatric literature seems to place a great deal of emphasis upon the present functioning

of the individual and his interaction with his environment" (Stricklin, 1974, p.12). This latter statement is of particular relevance to abortion counselling. The life history covers past experiences and the ability to cope with stress, while abortion counselling is ostensibly crisis intervention and as such focuses on the present situation and the patient's resources to deal with it.

The psycho-social history used began with a description of the family composition of the patient's index family, including the ages of either the parents or spouse, their occupations, ages of siblings or children and their occupations or school standards. Such a description gave the interviewer a general picture of the family of origin as well as the likelihood of this particular infant being accommodated within its structure. Past and current religious practices were taken fully into account, since these might be some guide to future guilt reactions. However, it should be noted that loss of faith is sometimes a manifestation of a depressive illness (Kenyon, 1969b). The accommodation and financial situation of the patient and her family not only indicated the socio-economic level of the family, but also the likelihood as to whether or not a further infant could be included.

The patient's developmental history was taken covering early milestones, any neurotic symptoms in childhood and through to the present, as well as the geographical background of the family of origin and if married, that of her own family. Her ability to cope with previous stressful events was explored. A history was taken of physical illnesses and any previously documented psychiatric illness, which included the diagnosis made, how she had responded to therapy and whether or not she was still in therapy. The history of any documented psychiatric illness in family members was also noted.

A description of the educational and occupational background was taken to assess both the patient's ability to

organise her life and the success with which she had done so; it was also seen as an indicator of her intellectual capacity and her level of independence. Her relationship with both peers and siblings reflected her ability to relate and adjust to the demands of others. Age appropriate relationships, as well as the patient's relationships with members of the opposite sex, were covered. Promiscuity, the use of contraception and the patient's attitude towards her sexuality were explored. If young, the patient's relationship with her parents was carefully explored and was considered highly relevant in assessing the future support of the patient. For example, how she saw them, how supportive she felt they would be towards her, how close a relationship it was, as well as their knowledge of and reaction to the pregnancy, were all discussed. In married women, the support of the husband took equal importance.

The patient was asked to describe how she saw her own personality in order to throw light on her self image, customary ego defences and level of impulse control. She was asked to compare her usual mood state prior to the pregnancy and that experienced at the time of the interview. The current mental status was of obvious importance, but how severe an emotional change had occurred since the discovery of the pregnancy, was difficult to assess when the patient presented alone and collateral data could not be obtained.

The emphasis in the interview then shifted to the present situation in order to elucidate the patient's relationship with her male partner. Information in the present areas was sought in a semi-structured way. When she had found out about the pregnancy, what she had done about it since, with whom she had discussed the matter, any attempt to abort the foetus and other alternatives she may have explored were all covered. Her attitude towards abortion was specifically noted. Other areas in which information was sought included the circumstances under which intercourse had taken place, of particular concern being young girls, those reporting rape, and the very naive. Reasons why the patient allowed herself

to fall pregnant were considered - ambivalence about contraception as well as embarrassment over obtaining contraceptives or their unavailability. Reasons given for saying the pregnancy was unwanted were discussed, of special concern being those who were ambivalent about the pregnancy, those who were being pressurized by others, and those who feared childbirth. The stress of the present pregnancy was also noted along with threats of suicide and illegal abortion, as well as available support from family, friends and society. The patient's ability to withstand stress had to be considered. Previous ability to withstand stress, a previous documented psychiatric history and whether or not psychiatric treatment should have been received, all helped in this respect. The possible outcome of therapeutic abortion or refused therapeutic abortion were both carefully noted in each individual case.

An attempt was made to understand the pregnancy in psychodynamic terms - what the present pregnancy meant to the patient and the extent of her maternal feelings.

The decision whether to recommend therapeutic abortion or not is rarely an easy one; there are many variables to be considered and it involves the most difficult area of psychiatry, viz. prognosis (Kenyon, 1969, p.244b). An attempt was made to assess each case on its own merits according to the law, without being swayed by either threats of suicide or illegal abortion. Where threats of suicide were made, they were assessed in relation to the total situation in which the patient found herself. They were never overlooked. Sometimes there was the added complication of an unsuccessful attempt at self-induced abortion having possibly damaged but not killed the foetus. Additional threats of illegal abortion were sometimes made. Here it was made clear that the assessment would not be swayed by such threats and the danger of such action was pointed out.

The stage of pregnancy at the time of consultation was considered carefully. Late attendance was sometimes

associated with ambivalence, while in other cases a late abortion was considered to be more stressful than continuation of the pregnancy. Such patients were always offered counselling.

On a number of occasions the patient was seen more than once to see how she reacted to the pregnancy over time, but in all cases there was the pressure of time and hospital waiting lists, leaving both staff and patients in a hurried situation. Social factors were explored, but only in relation to the effect they might have had on the psychiatric status of the patient. For the married woman such factors as the state of the marriage, relationship with husband, whether husband is the father, other children, etc., with the single woman such factors as how the pregnancy could affect her life style, educational and occupational status, were explored.

All other options apart from termination of pregnancy, were discussed thoroughly with each patient, as well as the understanding of and attitude towards abortion.

Kenyon (1969, p.244b) states that "in the light of the mental state, previous history, personality and present circumstances, if it is considered that continuation of the pregnancy would cause a serious deterioration (with or without the possibility of a suicide attempt) in the mental condition; and all other methods of treatment are unlikely to prevent this, then termination would be recommended." This may be used as a guideline in interpreting the South African law where 'permanent' mental ill health is difficult to determine.

<u>Case Example No. 1</u> — <u>Therapeutic Abortion not Recommended</u>

Miss M.E., aged 22 years and 11 months, was referred from the gynaecological outpatient clinic with a confirmed pregnancy of 16 weeks gestation. She came from a White middle class Afrikaans speaking family. She was co-operative but on the verge of tears throughout the interview, and very confused about her situation.

Miss M.E. was the third of 6 siblings. Her father had

died when she was aged 11 years. Her mother remarried when she was 19 years old but was divorced three years later. All her siblings were in employment and three were married, two with children. Her mother was a matron at a home for the aged.

Miss M.E.'s developmental history was normal with no known neurotic traits in childhood and no personal or family history of psychiatric illness. She had started school at age six years and attended two primary schools but the same high school throughout. She left school after having passed Std. IX. No problems in either behaviour or academic areas at school were admitted. After leaving school, she worked as a nurse aide for six months but had to leave her job as she could not stand on her feet all day. For the following 3½ years she worked as a radio operator at an airforce base. For the 18 months prior to presentation she had been employed as a bank clerk. No difficulties in her work and relationships at her various jobs were admitted.

The patient stated that she was very fond of her mother and felt that her mother had done a lot for her. She said that her mother was a very religious person and had brought up all the children very strictly. She felt indebted to her mother and did not wish to tell her of the pregnancy as she felt 'it would hurt her too much'. She stated that she had been very fond of her father and had been closer to him than to her mother and was very upset by his death. She did not like her stepfather. She described her family as being close-knit and all the siblings being very fond of each other and each maintained a reasonable amount of contact although they were all separated geographically. She felt she could not tell her siblings of the pregnancy either.

The patient said that she got on well with people superficially but had few close friends. She had had two steady boyfriends, each for over a year, prior to her relationship with the reputed father of the child. She had had no sexual intercourse prior to this and had had sexual intercourse with

this man, using no form of contraception, for the past 18 months prior to presentation.

The patient had known the reputed father for four years. She had initially been boarding in his house. He was married at the time and had three children. One year after she had been living with him and his wife, their marriage broke up with the reputed father gaining custody of the three children. The patient remained in the house as a boarder for a number of months until her mother told her that she did not approve of the situation. She then moved away but returned to the reputed father after six months and they started having a sexual relationship. She expressed very ambivalent feelings about her relationship with the reputed father and her pregnancy. At the time of presentation she felt she would like to go away and think about the situation alone. With regard to her pregnancy, the patient admitted that she ignored the situation for the first 12 weeks, although she did have the pregnancy medically confirmed during that time. She had not told the reputed father. She felt she could not marry him as her mother disapproved of him. Her wish to have the pregnancy terminated was due to her mother's possible reaction and her own adamant, negative feelings about adoption. She was clearly very ambivalent.

<u>Case Example No. 2</u> <u>Therapeutic Abortion Recommended</u>

Mrs. E.Y., aged 22 years and 9 months, was referred for an opinion on therapeutic abortion with a seven week pregnancy. She was White, divorced and had a three year old son. She came from a lower middle class family. During the interview she was co-operative but showed little feeling when discussing the present situation. She looked unwell and admitted that she was very tense.

Mrs. E.Y. was the younger of two children. She had a 32 year old brother who was married with two children. Both her parents were still alive and in their late 50's.

The patient herself was the result of an unplanned but

legitimate pregnancy. She was a breech birth and obstetrical handling during delivery resulted in her sustaining a back injury. She said that she had been told that she cried 'non-stop' until she was six months old. Her milestones were normal. She had severe temper tantrums between the ages of three and six years - "I've always been very stubborn." She had bitten her nails since childhood. At the age of 14 years, she was diagnosed as having a duodenal ulcer which had given her trouble up to the time of presentation. At 21 years she had a tonsillectomy. She had not been seen by a psychiatrist previously but stated, "I feel I should have done." Her son was attending the Child Guidance Clinic for temper tantrums at the time of presentation. There was no family history of psychiatric treatment.

The patient started school at age five years. Severe temper tantrums continued until she was expelled from school in Std. II when she stabbed a pupil with a pen. She disliked school throughout. After completing her primary education at another school, she went to high school where she repeated Std. VII, not due to failure but because "the teacher said I wasn't old enough to go up." She was expelled due to uncontrollable behaviour when repeating Std. VII. She was then placed as a boarder in another high school. She was expelled from the hostel after one month but remained as a day student, gaining a second class matric at 18 years. Since leaving school the patient had held numerous jobs - modelling, typing, saleslady - and had moved a number of times. At presentation she was doing freelance material designing.

In discussing her family relationships, she stated that she was very fond of her father and loved him very much but felt that he did not understand her. She did not feel close to her mother, whom she felt was a dull person. She talked about her in such statements as: "She's all right, she's my mother." "I cannot do anything about her." The patient felt there was a tremendous generation gap between herself and her brother. She said that he turned against her when she was expelled from school at age 14 years. She had had

very little contact with him since.

The patient described herself as having numerous friends - 'all weird'. She stated that she always told everyone her problems, tended to be the leader in her relationships with others, and did not appear to form lasting relationships. Her first relationship with a member of the opposite sex with sexual involvement was at the age of 14 years. She fell pregnant from this man at age 16 years, had an illegal abortion and broke off the relationship. During her matric year she went out with a number of different men and had sexual intercourse regularly. She met her husband when she was aged 18 years. After falling pregnant, she married him in March 1970. She wanted another abortion but he wanted her to keep the child. They were divorced in 1971. After the divorce, the patient had a number of boyfriends with sexual intercourse frequently, but had no steady boyfriend.

The patient admitted to having used dagga from the age of 13 years and also to using LSD frequently over the two years prior to presentation.

The reputed father of the presenting pregnancy was a 23 year old freelance artist. The patient was extremely angry about her pregnancy. She had been on a contraceptive pill for three years. Two months prior to her presentation she had been placed on a different contraceptive pill due to developing ovarian cysts. The patient felt that she could not marry the reputed father as she felt it would only result in the same sort of relationship as she had had with her ex-husband. She was quite adamant about having an abortion, whether gained legally or not.

In the following section of this chapter, both of these cases are discussed further in the light of the interview with the consultant psychiatrist and the recommendations made.

Interview with the Consultant Psychiatrist

The following morning after the patient had been seen by the psychiatric social worker, the history was presented to the consultant psychiatrist. He and the psychiatric social worker discussed the data gathered the previous day, prior to interviewing the patient. By this means the consultant psychiatrist was able to focus more specifically on individual areas of each patient when interviewing the patient. A joint interview was held with the patient, the consultant psychiatrist and the psychiatric social worker. Focus was placed on the present situation and assessing the patient's ability to cope with stress

If the consultant psychiatrist considered that a clear recommendation for therapeutic abortion could be made, the patient was referred directly back to the Department of Obstetrics and Gynaecology, with the consultant psychiatrist giving such recommendation as his opinion. If he felt that a clear recommendation for refusal of abortion could be made, the patient was seen directly after the refusal by the psychiatric social worker both for support and to explore the various alternatives. If the patient so wished, she could make further appointments to see the psychiatric social worker and was, in fact, encouraged to do so. The patient was also referred back to the Department of Obstetrics and Gynaecology for ante-natal care.

In some cases the consultant psychiatrist saw the patient on more than one occasion before giving an opinion, and in other cases he would call in a second consultant psychiatrist for another opinion. These cases were usually characterized by ambivalence on the part of the patient when a clear indication for recommending therapeutic abortion existed, or where the consultant psychiatrist felt that he wanted to see how the patient reacted over a period of time. However, in both instances time, the length of pregnancy and availability of hospital beds were hindering factors. After the therapeutic abortion operation, the patient was recontacted by the

psychiatric social worker if the patient had not been referred for more specific psychiatric treatment by the consultant psychiatrist.

Case Example No. 1. Termination not recommended.

Psychiatric opinion given on the first case.

> "Patient seen at interview. Composed although obviously worried. I do not see an indication on present evidence, but I think it is important to follow her up and help throughout the pregnancy. IQ clearly normal from interview performance."

Psychiatric opinion forwarded to referring gynaecologist.

> "We obtained a full history from the patient and saw her at interview. I do not think that there is a cause for termination on mental health grounds, although she is certainly in a difficult social situation. Also her delay in requesting termination suggests some ambivalence.
>
> "To summarize, I cannot recommend termination on present evidence. We will try to follow her up and help her through her pregnancy."

The patient was seen by the psychiatric social worker directly after the refusal. Alternatives were discussed and she agreed to have a conjoint interview with the reputed father the following week. When the patient failed to attend, the psychiatric social worker contacted her telephonically at home. The patient was angry about the whole situation but particularly the refusal for termination. She stated over the 'phone that she did not feel she needed to re-attend, but would recontact when necessary. She said she had discussed her situation with the reputed father who asked her to keep the child, and she had decided to do so. They had discussed marriage but had not come to a clear decision about it. The patient intended staying with the reputed father throughout the pregnancy and at her job for a further two months. At this stage, she refused further contact or assistance.

Case Example No. 2. Termination recommended.

Psychiatric opinion given on the second case.

> "This girl has a very disturbed history and it is clear that she has a gross personality disorder. Apart from her generally unstable way of life, she has been on dagga and LSD for a long time. Some years ago she tried to gas herself.
>
> "She already has one child and finds the care of this child a problem. A continuance of this pregnancy would result in a deterioration in her mental health, probably an increase in abuse of drugs with the development of an increasing degree of pregnancy and a risk of suicide.
>
> "Termination of pregnancy recommended."

Psychiatric opinion forwarded to the referring gynaecologist.

> "This girl displays a gross personality disorder with a history of a chaotic life style from an early age. She becomes depressed and attempts to solve her problems with the abuse of drugs and 'tripping'. She has a history of a previous suicide attempt.
>
> "A continuance of this pregnancy can only result in a marked deterioration in her already disturbed emotional make-up and I recommend termination of pregnancy. She has agreed to undergo psychiatric treatment."

The patient returned to the psychiatric consultant after the abortion operation. She was described as "certainly looking much better and not exhibiting any anxiety or depression." After failing to keep two further appointments, she was considered to be 'not well motivated', although 'she has a severely disturbed personality', and the case was closed until she requested to re-attend.

Aims of the Service

The service was initially started to accommodate the changing legal approaches to abortion. It was considered that a consistent opinion was important, recognising the constraints determined by the length of pregnancy, as well as the hospital waiting list. Efficiency and consistency were therefore aims of the service, as well as the personal care of each individual, so that each could be assessed as unique within the framework of the law. Thus with some cases, an opinion was given after one interview with the patient, while in others relatives would be seen, or a second psychiatric opinion would be requested. Follow-up services were provided and again individualized for each person, so that one might be referred for ongoing psychiatric treatment while another would be requested to see the psychiatric social worker for a routine follow-up interview. The aims of such follow-up were firstly, to further assist the patient if this seemed necessary, with physical or emotional needs, and secondly, to learn further about the sequelae of recommending or not recommending therapeutic abortion on psychiatric indications. Careful records were kept on the number of patients seen and the recommendations made so that future reference could be made to them.

Criticisms of the Service

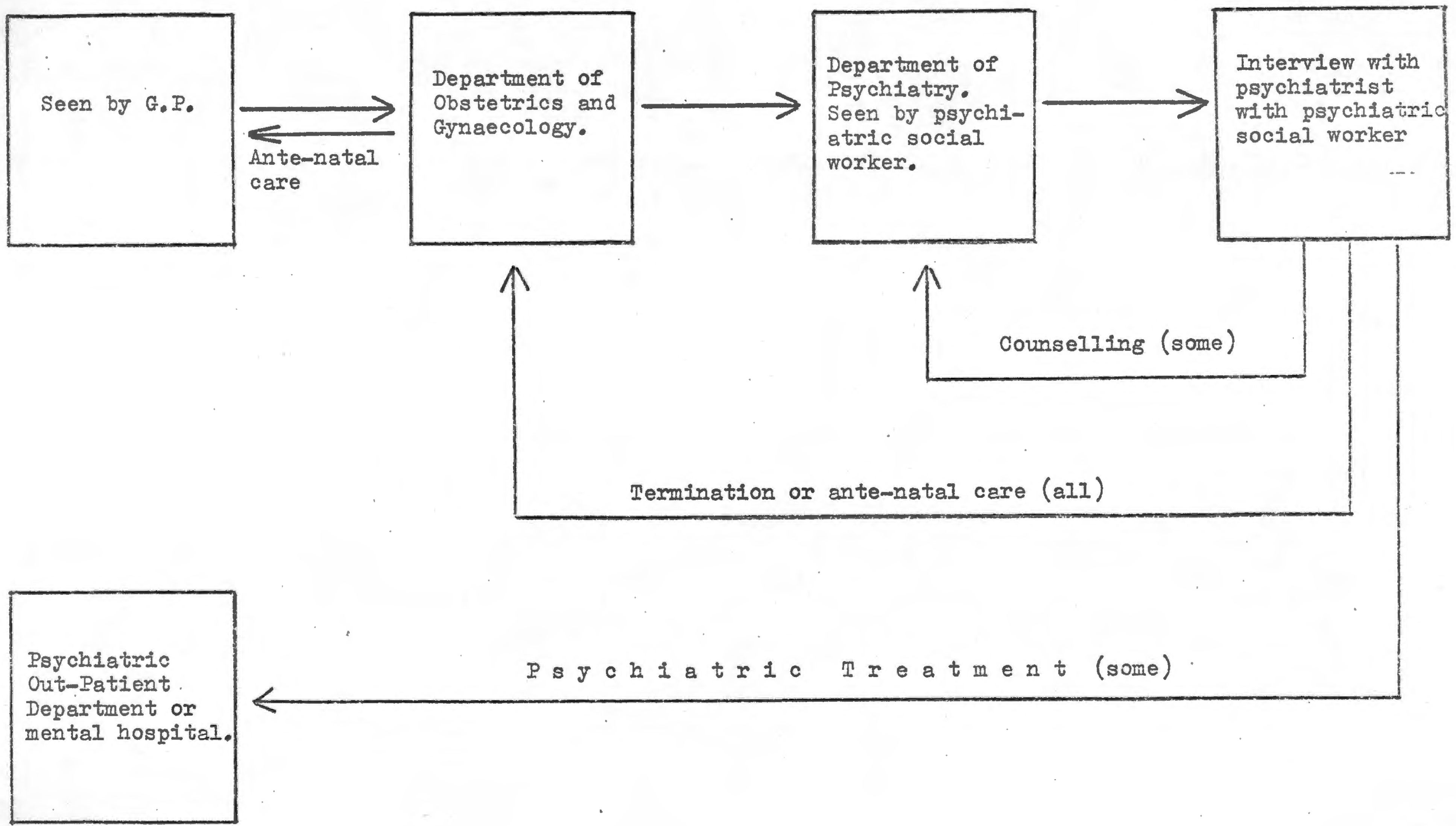
The need to maintain a certain level of efficiency may, at times, have been done to the detriment of the patient. The consultant psychiatrist is very much aware of the time factor in the assessment of such cases, but time should never take precedence over the needs of the patient. The psychiatric assessment takes a great deal longer than the gynaecological examination and delays could be interpreted by the gynaecological staff as representing inefficiency or a lack of concern for the patient.

The fact that the same psychiatric consultant and the same psychiatric social worker were involved in the assessment

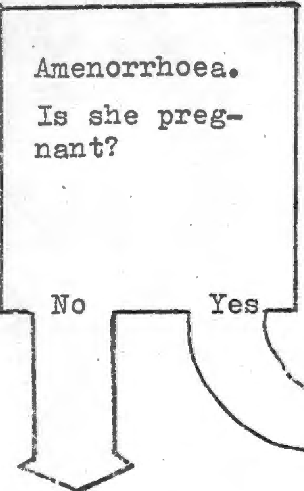
introduced a bias into the decision making process. No matter how carefully one's own opinion may be consciously kept in check, unconsciously such values might well affect the decision.

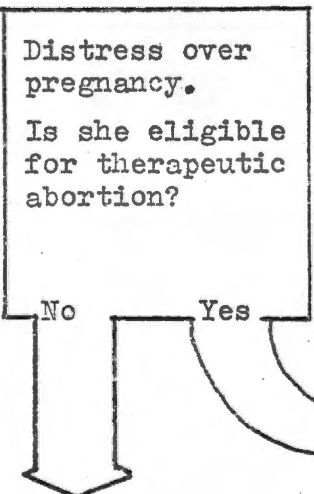
With the eagerness to obtain follow-up data on as many cases as possible for both statistical records and for later reference, some patients may have felt that their privacy was being infringed upon.

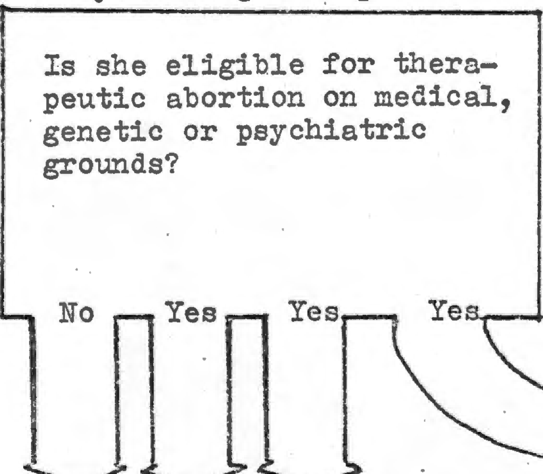
FLOW CHART ILLUSTRATING THE PROCESS OF REFERRAL OF EACH PATIENT

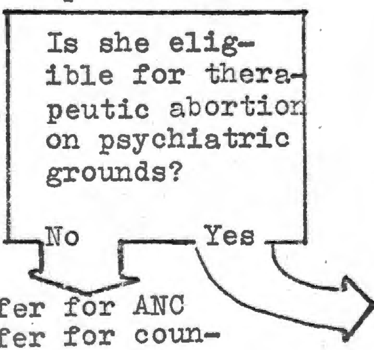


DECISION TREE ILLUSTRATING THE DECISIONS MADE WHEN A WOMAN PRESENTS FOR THERAPEUTIC ABORTION









CHAPTER 6

AIMS AND HYPOTHESES OF THE PRESENT STUDY

Aims of the Study

1. To study the implications of recommending or not recommending therapeutic abortion on psychiatric grounds for patients referred for such assessment by the Department of Obstetrics and Gynaecology of Groote Schuur Hospital, working within the framework of the Abortion and Sterilization Bills of 1973 and 1974, and the Abortion and Sterilization Act 2/75 over a period of 15 months - 1/2/74 - 31/5/75.

2. To compare the decisions made with regard to therapeutic abortion during the period 1/3/74 - 31/5/74 under the Abortion and Sterilization Bill, with those made during the period 1/3/75 - 31/5/75 under the Abortion and Sterilization Act 2/75, and to consider the significance of any differences found.

3. To describe the personal and social characteristics of patients of all population groups presenting for psychiatric assessment for therapeutic abortion over the period 1/2/74 - 31/5/75.

4. To identify those characteristics which distinguished the patients in the group recommended for therapeutic abortion from those in the group not recommended for therapeutic abortion.

5. To isolate those factors in the psycho-social history which appear to have influenced the decisions made.

6. To conduct a follow-up study of both groups between 12 and 18 months after the patient's original presentation in order to study the sequelae of the decision whether or not to terminate.

Hypotheses of the Study

Hypothesis Number 1

Even if there are no data which can accurately predict the risk to a woman's mental health of a continued pregnancy, nevertheless factors customarily considered 'psychiatric' influence the decisions made about its termination on psychiatric grounds.

'Psychiatric' Data

- A disrupted family background.
- The patient herself having been an illegitimate, adopted or fostered child.
- Behaviour difficulties in school years.
- Erratic employment record.
- A history of poor social adjustment.
- Evidence of an inability to cope with stress.
- Documented previous or current psychiatric disorder in the patient or in her family.
- A previous suicide attempt.
- A poor image of self at the time of the interview.
- Evidence from the psychiatric state examination at the time of the interview of mental illness falling within the Mental Health Act 18/73.

Hypothesis Number 2

Given a pregnancy which is thought to constitute a serious threat to the mental health of the mother, if measurable criteria cannot be specified before a decision is made by a psychiatrist, then factors other than those customarily considered 'psychiatric' are likely to influence the decision made, viz. psycho-social factors.

'Psycho-Social' Data

- Age.
- Ethnic group.
- Social-economic class.
- Lack of education.
- Pattern of heterosexual relationships.
- Parity.
- Previous illegitimate pregnancies.
- Previous terminations.
- Lack of support from the patient's family or the reputed father of the child in the present pregnancy.

Hypothesis Number 3

Attitudes to contraception and unwanted pregnancy on the part of the patient and/or her family contribute to a decision not to terminate a pregnancy on psychiatric grounds. These factors include:

- Erratic use of contraception.
- Presentation during the second trimester of pregnancy.
- Ambivalence over the pregnancy and/or the abortion.
- Acceptance of the pregnancy.
- Evidence of emotional support from parents and/or the reputed father of the child.

Hypothesis Number 4

If therapeutic abortion is refused on psychiatric indications, then all patients will experience negative feelings to the continued pregnancy.

Hypothesis Number 5

In the absence of psychiatric grounds for the termination of an unwanted pregnancy, little serious damage to the mental health of the patient ensues if termination is refused, as long as counselling and psychiatric services are available.

CHAPTER 7

METHODOLOGY

Initial data was gathered by the psychiatric social worker in her first comprehensive interview with the patient. The psycho-social data was gathered under the areas which were described in detail in Chapter 5:

1. Identifying details.
2. Family and personal history.
3. Interpersonal relationships.
4. Present life situation.
5. Presenting problem.

The patient's psychiatric status was assessed at a later interview by the consultant psychiatrist. The intelligence quotient of patients who were considered to have below average intelligence were assessed using a range of intelligence tests. The tests used were invariably the Old Individual Scale of the National Bureau (Fick, 1939) or the Wechsler Bellevue Adult IQ Scale (South African version) (National Institute for Personal Research, undated) and the Draw-a-Man Test (Harris, 1963). Further data was gathered at the immediate follow-up interview which took place either after the abortion or within a week after the refusal. All this information was transformed onto a set of white punch cards, one per patient (see Appendix D for the coding of these cards). This initial data was retrieved manually and grouped according to personal, historical and present data (see Appendix E for these categories). Some of these categories were not mutually exclusive and specific definitions were used (see Appendix F for these definitions). Information covering a wide range of variables could be easily extracted by hand and comparisons made between the two groups of patients - the terminated and the not terminated.

A later follow-up study was conducted endeavouring to recontact all patients, those terminated and those not terminated, at a period of 12 to 18 months after initial presentation. Patients were contacted preferably by telephone, otherwise by a personal letter. Each patient was requested to attend a further follow-up interview which would be arranged at a time convenient to her. At the interview the patient was requested to complete a questionnaire on her feelings about the pregnancy at the time of initial presentation as she remembered them, and her present feelings about either the abortion or other fate of the pregnancy. All the interviews were arranged and conducted by the same psychiatric social worker who had seen the patient at her initial presentation. Personal data about the patient since her initial contact was also gathered by means of a questionnaire which was used in a semi-structured manner in the interview. Some patients refused a personal interview but were prepared to discuss their situation telephonically. Personal data was gathered by this means, and the questionnaire on the emotional factors was sent to the patient to complete and return. Other patients refused to discuss the situation at all and a number were considered untraceable. Patients living at a distance were contacted by letter and asked to write to the psychiatric social worker telling her about their life situation since they had been seen at the clinic. If a reply was received, the questionnaire on emotional responses was forwarded to the patient to complete and return. The responses were rated from 1 to 5 according to their intensity, i.e. 1 meaning that the feeling was not present at all whereas 5 meant a considerable degree of that response. Data was also gathered from collateral sources - relatives, friends, outside agencies and hospital records - particularly when the patient herself was unavailable. Both sets of questionnaires were phrased according to whether the patient had or had not had an abortion. (Examples of these questionnaires are given in Appendix G).

The study covered the period 1/2/74 - 31/5/75. The

Abortion and Sterilization Act became law in March 1975 so that patients concerned in this study were largely those referred prior to the Act. In order to make a comparison between the decisions made and the patients presenting during the aegis of the 1973 and 1974 Bills with that of the Act of 1975, patients presenting between 1/3/74 and 31/5/74 were compared with those referred during the same period a year later, i.e. 1/3/75 - 31/5/75 when the Act was passed.

The raw data gathered from the initial presentation and the follow-up of 12 to 18 months later were submitted to computer analysis.

The terminated and not terminated groups were compared in terms of the initial psycho-social data taking 40 variables into consideration. (These are listed in Appendix I).

The data was set up in 2 x N contingency tables and Chi-Square Tests were performed on these. Significant differences ($p < 0,05$) were noted and extracted. (See Appendix J for an explanation of the statistical methods used).

The follow-up data gathered from 12 to 18 months after initial presentation was similarly examined in 2 way tables and again significant differences in the two groups were identified.

A discriminant analysis on initial presenting data was also performed to assess the weighting of the variables that appeared to have influenced group allocation.

<u>A Brief Evaluation of the Methodology</u>

A decided advantage of this prospective study is the fact that all the material gathered was collected by the same personnel, while all the follow-up data was gathered by the psychiatric social worker who had had the initial contact with the patient. This automatically led to consistent clinical practice and consistent handling of the data. It also helped to encourage patients to present at the follow-up interview since the psychiatric social worker who made all the contacts was known to them.

However, this consistency does have a specific disadvantage as it immediately introduces a personal bias into the study, although attempts have been made to keep them in check. This criticism may also be levelled at the somewhat arbitrary categories of the data and for this reason, an attempt was made to define those categories which were not mutually exclusive. The element of human error in the synthesizing of the material is also acknowledged.

A further limitation of this study is the fact that a large portion of the sample studied presented prior to the Abortion and Sterilization Act of 1975. The period covered only coincided with the first three months of the Act. Prior to this, the draft Bills of 1973 and 1974 were used as guidelines.

CHAPTER 8

RESULTS GAINED FROM INITIAL PRESENTATION

During the period 1/2/74 - 31/5/75 a total of 197 women were seen for assessment for therapeutic abortion on psychiatric indications. Of the total, 107 (54%) were recommended for termination of pregnancy and 90 (46%) were refused therapeutic abortion.

TABLE 1

HISTOGRAM SHOWING THE TOTAL NUMBER OF REFERRALS FOR THE PERIOD 1/2/74 - 31/5/75

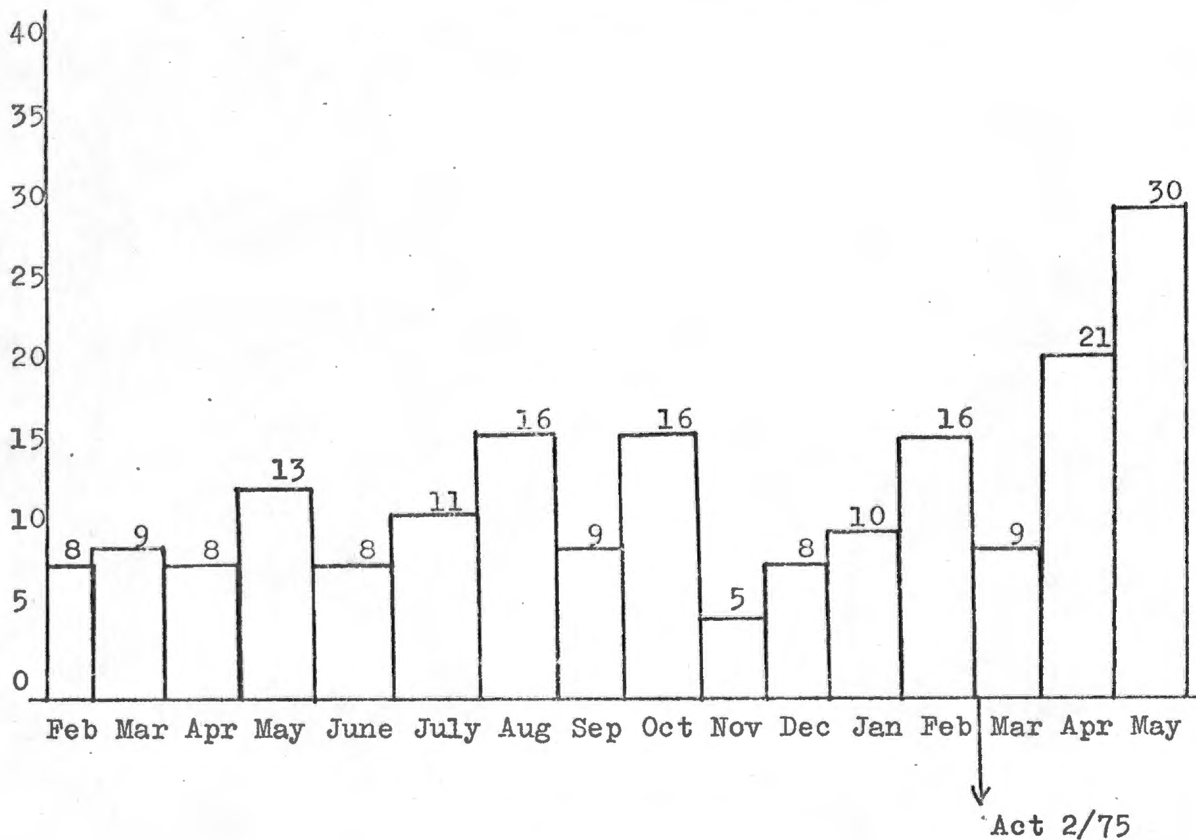
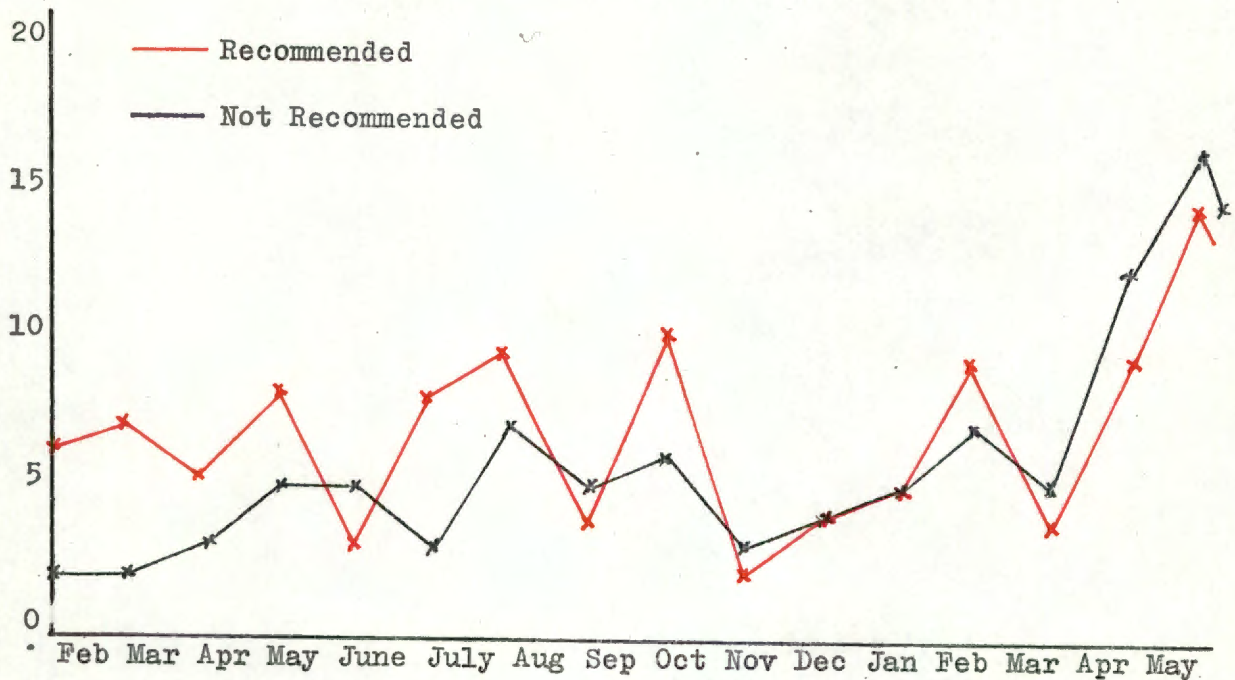


TABLE 2

GRAPH SHOWING THE NUMBER OF PATIENTS RECOMMENDED AND NOT RECOMMENDED FOR THERAPEUTIC ABORTION OVER THE PERIOD 1/2/74 - 31/5/75



'PSYCHIATRIC' DATA

The following tables present the 'psychiatric' data referred to in hypothesis number one in Chapter 6. Two tables are given for each variable. The first presents the total sample, Sample A, the second, Sample B, those remaining after 29 cases are excluded on account of rape or mental retardation (note that these also come under the rubric of the Immorality Act 23/57). Two groups are presented - those recommended and those not recommended - the total remaining constant. The figures in the columns indicate the number of persons in each group in whom this variable was identified. Chi-square, degrees of freedom and probability values are shown either on the right hand side or underneath.

TABLE 3

SAMPLE A

Data	Term Gp (107)	Not Term Gp (90)	Total (197)	X^2	df	P
Disrupted family background	41	33	74	0,0056	1	NS
Family history of psychiatric care	29	25	54	0,011	1	NS

The presence of a disrupted family background or family history of psychiatric care were both found to be not significant in relation to the decisions made in the total sample.

SAMPLE B

Data	Term Gp (107)	Not Term Gp (90)	Total (197)	X^2	df	P
Disrupted family background	33	29	62	0,357	1	NS
Family history of psychiatric care	25	23	48	0,072	1	NS

Again, the presence of either a disrupted family background and a family history of psychiatric care did not affect the decision significantly when the rape and mentally retarded cases were removed.

TABLE 4

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Illegitimate, adopted, fostered child	5	5	10	0,079	1	NS
Behaviour/academic difficulties at school	25	18	43	0,324	1	NS
Poor socializing ability	46	26	72	3,605	1	NS

There was found to be no significant difference between the two groups - recommended for termination and not recommended for termination - in relation to the total sample when the three variables illegitimate, adopted or fostered child, academic/behaviour difficulties at school and poor socializing ability were submitted to statistical analysis.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Illegitimate, adopted, fostered child	3	5	8	0,107	1	NS
Behaviour/academic difficulties at school	14	16	30	1,116	1	NS
Poor socializing ability	27	24	51	0,191	1	NS

The three variables were not influenced by the expulsion of the rape and mental retardation cases.

TABLE 5

SIGNIFICANCE OF WORK RECORD

SAMPLE A

Work Record	Term Gp	Not Term Gp	Total
Broken word record	12	11	23
Stable work record	55	55	110
Still studying	40	24	64
TOTAL	107	90	197

X^2 = 2,595 (2df); NS

No significant difference was found between the two groups - terminated and not terminated - in relation to the variable of work record in the total sample.

SIGNIFICANCE OF WORK RECORD

SAMPLE B

Work Record	Term Gp	Not Term Gp	Total
Broken work record	25	22	47
Stable work record	49	52	101
Still studying	9	11	20
TOTAL	83	85	168

X^2 = 0,456 (2df); NS

The factor of work performance remained not significant in the sample of 168.

TABLE 6

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Poor self image	47	31	78	1,837	1	NS

A poor self image was found to be a not significant variable between the two groups in the total sample.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Poor self image	32	30	62	0,077	1	NS

In the modified sample of 168, the variable poor self image remained not significant.

TABLE 7

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Previous psychiatric treatment	13	18	31	2,272	1	NS
Previous suicide attempt	9	6	15	0,211	1	NS

There was found to be no significant difference between the two groups in relation to the variables previous psychiatric treatment and previous suicide attempt. However, it is of interest to note that a total of 31 patients (18 not recommended) had received previous psychiatric treatment and that a total of 15 patients (6 were refused termination) had made a previous suicide attempt.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Previous psychiatric treatment	9	16	25	1,528	1	NS
Previous suicide attempt	8	6	14	0,106	1	NS

In the sample of 168 both variables remained not significant.

TABLE 8

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Threats of suicide if refused	16	14	30	0,013	1	NS
Threats of illegal abortion if refused	19	24	43	2,274	1	NS

Although there was no significance between the two groups in relation to the variables of threatening suicide or illegal abortion if refused, a total of 30 patients threatened suicide and 43 patients threatened illegal abortion.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Threats of suicide if refused	16	13	29	0,229	1	NS
Threats of illegal abortion if refused	19	23	42	0,198	1	NS

In the sample of 168 patients, both of the above variables were again not significant.

TABLE 9

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Referred for psychiatric treatment	17	5	22	5,260	1	$<0,025$

There was a significant difference between the two groups in relation to the variable, referred for psychiatric treatment, with more patients falling within the termination group.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Referred for psychiatric treatment	15	5	20	4,844	1	$<0,027$

There was still a significant difference between the two groups in the amended sample with ¾ of the patients remaining in the termination group.

TABLE 10

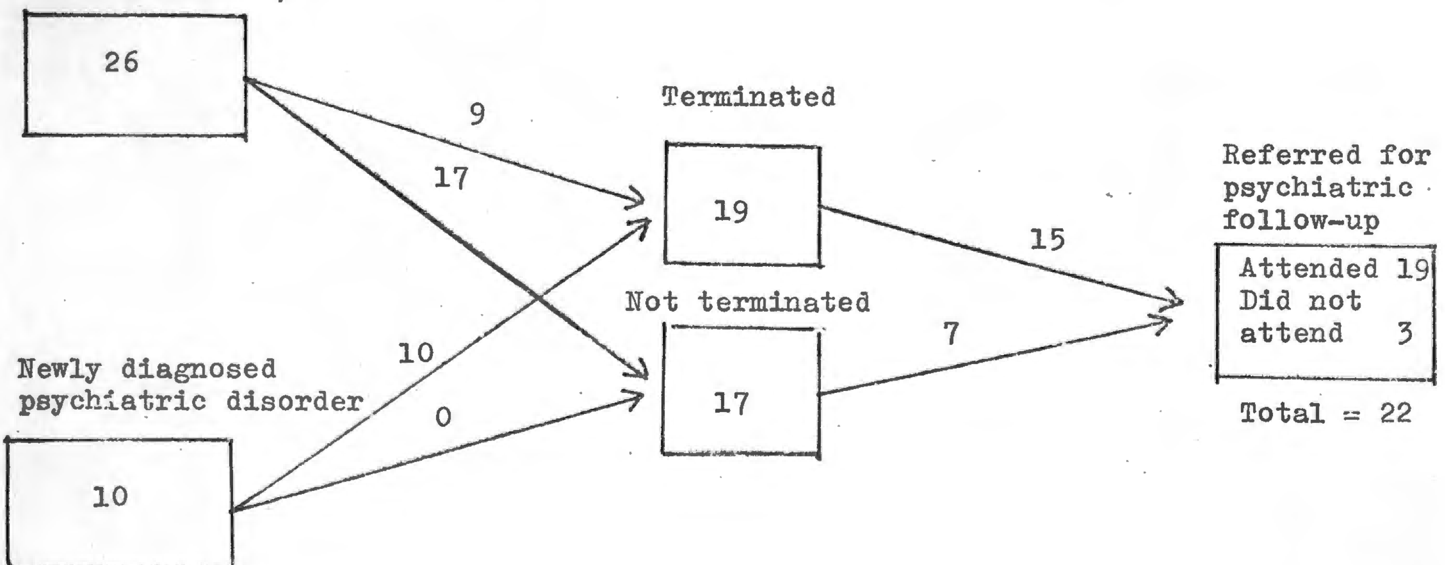


Table 10 illustrates the outcome of the abortion decision of the identified psychiatric patients (excluding those who were mentally retarded). Of note is the fact that 2/3rds of those with documented previous and/or current psychiatric disorder were not terminated, while all those with newly diagnosed psychiatric disorder were terminated.

The diagnosis of the 31 patients who had received previous psychiatric treatment covered all the major diagnostic categories:

1. Mentally retarded (5) (4 recommended)
2. Neurotic depression (8) (2 recommended)
3. Personality disorder (10) (4 recommended)
4. Psychosis (3) (3 recommended)
5. Adolescent turmoil (5) (0 recommended)

Diagnostic categories of those patients newly diagnosed as having psychiatric disorder included:

1. Mentally retarded (2) (2 recommended)
2. Neurotic depression (7) (7 recommended)
3. Personality disorder (3) (3 recommended)

Diagnostic categories of the total number of patients (27) referred on for psychiatric treatment, including those newly diagnosed and those with previous documented and/or current psychiatric disorder, were as follows:

1. Mentally retarded (5) (4 recommended)
2. Neurotic depression (8) (7 recommended)
3. Personality disorder (8) (5 recommended)
4. Psychosis (3) (3 recommended)
5. Adolescent turmoil (3) (0 recommended)

TABLE 11

Data	Term Gp (107)	Not Term Gp (90)	Total (197)
IQ less than 50	4	0	4
IQ 50 but less than 80	10	1	11

All those patients with moderate or severe mental retardation were psychologically tested and with one exception, all were recommended for therapeutic abortion.

'PSYCHO-SOCIAL' DATA

The following tables present the 'psycho-social' data referred to in hypothesis number two in Chapter 6.

TABLE 12

SIGNIFICANCE OF AGE

SAMPLE A

Age	Term Gp	Not Term Gp	Total
Under 16 years	16	0	16
16 years but under 21 years	28	28	56
21 years but under 30 years	38	51	89
30 years but under 39 years	21	9	30
39 years and above	4	2	6
TOTAL	107	90	197

$X^2 = 18,098$ (4df); $p < 0,005$

The significance of the age distribution appears to be accounted for by the fact that all those under the age of 16 years were recommended for therapeutic abortion and by the fact that more of those over the age of 30 years fell in the termination as opposed to not termination group.

SIGNIFICANCE OF AGE

SAMPLE B

Age	Term Gp	Not Term Gp	Total
Under 14 years	2	0	2
14 years but under 16 years	6	0	6
16 years but under 18 years	11	9	20
18 years but under 21 years	9	19	28
21 years but under 30 years	34	47	81
30 years but under 39 years	17	8	25
39 years and above	4	2	6
TOTAL	83	85	168

$X^2 = 17,743$ (6df); $p < 0,0069$

The above table shows the significance of age after removing 29 cases of rape or mental retardation. Note that in girls under the age of 18 years, in approximately 2/3rds termination was recommended, which includes all under the age of 16 years.

TABLE 13

SIGNIFICANCE OF ETHNIC GROUP

SAMPLE A

Ethnic Group	Term Gp	Not Term Gp	Total
White	57	73	130
Coloured	45	16	61
Other	5	1	6
TOTAL	107	90	197

$X^2 = 17,082$ (2df); $p < 0,001$

The significance between the termination and not termination group appears to be accounted for by the fact that there were larger numbers of Coloured patients recommended for termination, but note in the modified sample, once patients had been excluded on account of rape and mental retardation, there was no significant difference - see Table 13, Sample B. Approximately 2/3rds of all patients presenting were White.

SIGNIFICANCE OF ETHNIC GROUP

SAMPLE B

Ethnic Group	Term Gp	Not Term Gp	Total
White	54	70	124
Coloured	26	14	40
Other	3	1	4
TOTAL	83	85	168

$X^2 = 6,975$ (2df); NS.

TABLE 14

SIGNIFICANCE OF SOCIAL-ECONOMIC CLASS

SAMPLE A

Social-Economic Class	Term Gp	Not Term Gp	Total
Social class I	0	0	0
Social class II	13	14	27
Social class III	40	39	79
Social class IV	22	21	43
Social class V and VI	32	16	46
TOTAL	107	90	197

X^2 = 3,198 (3df): NS.

Social-economic class was found to be not significant in the total sample. Most patients came from the middle and working class population.

SIGNIFICANCE OF SOCIAL-ECONOMIC CLASS

SAMPLE B

Social-Economic Class	Term Gp	Not Term Gp	Total
Social class I	0	0	0
Social class II	13	14	27
Social class III	36	37	73
Social class IV	18	19	37
Social class V	14	13	27
Social class VI	2	2	4
TOTAL	83	85	168

X^2 = 0,999 (4df); NS.

Social-economic class distribution was similar in the amended sample.

TABLE 15

SIGNIFICANCE OF MARITAL STATUS

SAMPLE A

Marital Status	Term Gp	Not Term Gp	Total
Unmarried	73	69	142
Married	25	16	41
Other	9	5	14
TOTAL	107	90	197

x^2 = 1,777 (2df): NS

Although the total sample was weighted by a large number of unmarried women, the numbers of those recommended were fairly evenly distributed between the two groups. This was also shown in Sample B below where, in addition, the marital status was more closely analyzed.

SIGNIFICANCE OF MARITAL STATUS

SAMPLE B

Marital Status	Term Gp	Not Term Gp	Total
Unmarried	52	65	117
Married	23	15	38
Divorced	5	4	9
Separated	3	1	4
TOTAL	83	85	168

x^2 = 4,216 (3df) ; NS.

TABLE 16

SIGNIFICANCE OF PARITY

SAMPLE A

Parity	Term Gp	Not Term Gp	Total
Nulliparous	75	64	139
Less than 4 children	15	22	37
4 or more children	17	4	21
TOTAL	107	90	197

$x^2 = 8{,}841$ (2df) ; $p < 0{,}025$

The significance of the variable, parity, appears to be accounted for by recommendation for termination being made in women with four or more children. This is also a feature of Sample B - in fact, all women who already had six children were recommended for termination.

SIGNIFICANCE OF PARITY

SAMPLE B

Parity	Term Gp	Not Term Gp	Total
Nulliparous	54	60	114
Less than 4 children	14	22	36
4 but less than 6 children	7	3	10
6 or more children	8	0	8
TOTAL	83	85	168

$x^2 = 11{,}671$ (3df) ; $p < 0{,}0086$

TABLE 17

SIGNIFICANCE OF EDUCATIONAL LEVEL

SAMPLE A

Educational Level	Term Gp	Not Term Gp	Total
No education / Primary school	26	9	35
High school	50	54	104
Matriculation	21	15	36
University	10	12	22
TOTAL	107	90	197

$x^2 = 8{,}186$ (3df) ; $p < 0{,}05$

More patients with little or no education were referred for termination. This included the mentally retarded, since when provision is made to exclude these patients, as well as those who had been rape victims, no significant difference between the two groups was found (see Sample B).

SIGNIFICANCE OF EDUCATIONAL LEVEL

SAMPLE B

Educational Level	Term Gp	Not Term Gp	Total
No education	1	0	1
Primary school	9	8	17
High school	43	51	94
Matriculation	20	14	34
University	10	12	22
TOTAL	83	85	168

X^2 = 2,956 (4df) ; NS.

TABLE 18

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Previous sexual partner(s)	31	44	75	8,224	1	$<$ 0,005
Previous illegitimate births	5	10	15	2,880	1	NS
Previous termination	7	4	11	0,407	1	NS

In the total sample, more patients who had had previous sexual partner(s) fell into the group not recommended for termination. Previous illegitimate births and previous terminations were not significant. These features were again reflected in Sample B.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Previous sexual partner(s)	27	43	70	4,915	1	$<$ 0,026
Previous illegitimate births	5	10	15	2,481	1	NS
Previous termination	7	4	11	0,044	1	NS

TABLE 19

SIGNIFICANCE OF THE RELATIONSHIP WITH THE REPUTED FATHER

SAMPLE A

Type of Relationship	Term Gp	Not Term Gp	Total
Rape	14	4	18
Promiscuous relationship	22	7	29
Longstanding relationship	71	79	150
TOTAL	107	90	197

$X^2 = 12,365$ (2df) ; $p < 0,005$

This table illustrates the fact that ¾ of those who admitted that the pregnancy was the product of rape or a promiscuous relationship, were recommended for termination.

TABLE 20

SAMPLE A

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Parental involvement	49	28	77	3,831	1	NS

It is of interest that in just under a half of the total sample, parents were involved.

SAMPLE B

Data	Term Gp	Not Term Gp	Total	X^2	df	P
Parental involvement	32	27	59	0,577	1	NS

The amended sample showed a similar result.

TABLE 21

SIGNIFICANCE OF SUPPORT FROM THE MALE PARTNER

SAMPLE A

Support from Partner	Term GP	Not Term Gp	Total
Supportive	37	46	83
Not supportive	26	25	51
No male partner	44	19	63
TOTAL	107	90	197

$X^2 = 9,520$ (2df) ; $p < 0,01$.

'Support from male partner' was found to be a significant feature in that more patients without a male partner were recommended for termination; this seems to be influenced by those who were excluded from Sample B below.

SIGNIFICANCE OF SUPPORT FROM THE MALE PARTNER

SAMPLE B

Support from Partner	Term Gp	Not Term Gp	Total
Supportive	35	47	82
Not supportive	26	24	50
No male partner	22	14	36
TOTAL	83	85	168

$X^2 = 3,590$ (2df); NS.

The following results are concerned with the attitudes held towards the pregnancy and/or abortion, as well as behaviour related to these attitudes. These results are specifically concerned with hypothesis number three.

TABLE 22

SIGNIFICANCE OF USE OF CONTRACEPTION

SAMPLE B

Use of Contraception	Term Gp	Not Term Gp	Total
Never used contraception	48	47	95
Used previously and given up	16	14	30
Failed contraception	19	24	43
TOTAL	83	85	168

X^2 = 0,70 (2df); NS.

Omitting the rape and mentally retarded cases the variable, the use of contraception, was not a significant influencing factor.

TABLE 23

SIGNIFICANCE OF GESTATIONAL PERIOD AT PRESENTATION

SAMPLE A

Length of Pregnancy	Term Gp	Not Term Gp	Total
Less than 8 weeks	14	10	24
8 but less than 12 weeks	64	42	106
12 but less than 16 weeks	15	18	33
16 but less than 20 weeks	9	10	19
20 weeks and more	5	10	15
TOTAL	107	90	197

X^2 = 5,800 (4df); NS.

In the total sample, gestational period at the time of presentation did not appear to be significantly different between the two groups. However, it should be noted that in pregnancies of over 12 weeks, fewer patients were recommended for termination.

SIGNIFICANCE OF GESTATIONAL PERIOD AT PRESENTATION

SAMPLE B

Length of Pregnancy	Term Gp	Not Term Gp	Total
Less than 8 weeks	13	10	23
8 but less than 12 weeks	51	42	93
12 but less than 16 weeks	11	16	27
16 but less than 20 weeks	7	8	15
20 weeks and more	1	9	10
TOTAL	83	85	168

X^2 = 8,632 (4df); NS.

In the amended Sample B the variable remained not significant.

TABLE 24

SAMPLE A

Attitude Towards the Pregnancy	Term Gp	Not Term Gp	Total	X^2	df	P
Ambivalent	15	39	54	21,112	1	$<$ 0,001
Accepting	22	32	54	5,524	1	$<$ 0,02
Denial of feelings	25	9	34	6,114	1	$<$ 0,085

The variables, ambivalence, acceptance and denial of feelings, were all found to be significant. Ambivalence about and acceptance of the pregnancy were more common in the group not recommended, while denial of feelings was more characteristic of those recommended for termination.

SAMPLE B

Attitude Towards the Pregnancy	Term Gp	Not Term Gp	Total	X^2	df	P
Ambivalent	13	37	50	14,295	1	$<$ 0,0002
Accepting	21	31	52	0,921	1	NS
Denial of feelings	13	8	21	0,983	1	NS

In the corrected sample, ambivalence remained significant, while acceptance and denial of feelings were found to be not significant.

TABLE 25

SAMPLE A

Attitude Towards the Pregnancy	Term Gp	Not Term Gp	Total	X^2	df	P
Angry	31	24	55	0,129	1	NS
Guilty	50	43	93	0,021	1	NS
Hurt	26	19	45	0,281	1	NS

Feelings of anger, guilt and hurt were all not significant in the total sample, as also found in Sample B.

SAMPLE B

Attitude Towards the Pregnancy	Term Gp	Not Term Gp	Total	X^2	df	P
Angry	24	25	49	0,009	1	NS
Guilty	44	42	86	0,097	1	NS
Hurt	22	20	42	0,071	1	NS

In summary, there was found to be a significant difference between the two groups - terminated and not terminated - in the total sample, with the following variables:

1. Age
2. Ethnic group
3. Parity
4. Educational level
5. Previous sexual partner(s)
6. Relationship with the reputed father
7. Referred for psychiatric treatment at assessment
8. Support from male partner
9. Feelings of: (a) Ambivalence
   (b) Acceptance
10. Denial of feelings

Discriminant Analysis

The discriminant analysis performed on the initial presenting data showed that the chief weighting factors in the decision to terminate or not appeared to be:

1. Referral for psychiatric treatment after the interview (this weighted in favour of termination).
2. Evidence of ambivalence over the pregnancy and/or abortion (this weighted against termination).
3. More than one intimate relationship (this weighted against termination).

CHAPTER 9

FURTHER RESULTS GAINED FROM INITIAL PRESENTATION

A. Comparison Between the Total Populations 1/3/74-31/5/74 and 1/3/75-31/5/75

During the period 1/3/74 - 31/5/74, a total of 30 patients were referred to the Abortion Clinic for an opinion on therapeutic abortion. Of these, 20 patients were recommended and 10 were not recommended. During the same period a year later, i.e. 1/3/75 - 31/5/75, during the first three months of the implementation of the Abortion and Sterilization Act 2/75, a total of 60 patients were referred, 27 patients were recommended for therapeutic abortion and 33 were refused.

Variables mentioned in Chapter 8 were, in the early and late groups, submitted to statistical analysis to see if there was a significant difference. The following tables set out some of these results. Variables are given in the same order as in the previous chapter.

TABLE 26

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Disrupted family background	7	21	1,270	1	NS
Family history of psychiatric care	7	17	0,255	1	NS

TABLE 27

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Illegitimate, adopted or fostered child	0	1			
Behaviour/academic difficulties at school	8	12	0,514	1	NS
Poor socializing ability	11	20	0,098	1	NS

TABLE 28

SIGNIFICANCE OF WORK RECORD

Work Record	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Broken work record	7	3
Stable work record	14	35
(Still studying	9	22)

$X^2 = 6,217$ (1df); $p < 0,02$

Note that those who were still studying are included in the table, but were not used in the statistical analysis. The significance here appears to be accounted for by the large number with a stable work record in the second sample for termination in the 1/3/75 - 31/5/75 period.

TABLE 29

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Poor self image	11	20	0,098	1	NS

TABLE 30

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Previous psychiatric treatment	3	9	0,432	1	NS
Previous suicide attempt	1	6			

No statistical analysis was performed on the variable, previous suicide attempt, due to the small numbers.

TABLE 31

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Threats of suicide if refused	3	14	2,320	1	NS
Threats of illegal abortion if refused	10	8	5,000	1	$< 0,05$

TABLE 32

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Referred for psychiatric treatment	4	4	1,097	1	NS

TABLE 33

SIGNIFICANCE OF AGE

Age	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Under 18 years	7	9
18 years but under 21 years	5	9
21 years but under 30 years	12	30
30 years and above	6	12

X^2 = 1,245 (3df); NS.

TABLE 34

SIGNIFICANCE OF ETHNIC GROUP

Ethnic Group	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
White	19	47
Black	11	13

X^2 = 2,301 (1df); NS.

TABLE 35

SIGNIFICANCE OF SOCIAL ECONOMIC CLASS

Social Economic Class	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Social class II	3	10
Social class III	15	24
Social class IV	3	15
Social class V and VI	9	11

X^2 = 4,551 (3df); NS.

TABLE 36

SIGNIFICANCE OF MARITAL STATUS

Marital Status	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Unmarried	24	39
Married Separated/divorced	6	21

x^2 = 2,142 (1df); NS.

TABLE 37

SIGNIFICANCE OF PARITY

Parity	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Nulliparous	24	40
One or more children	6	20

x^2 = 1,730 (1df); NS.

TABLE 38

SIGNIFICANCE OF EDUCATIONAL LEVEL

Educational Level	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
No education Primary school	4	8
High school	16	33
Matriculation	5	12
University	5	7

x^2 = 0,502 (3df); NS.

TABLE 39

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	x^2	df	P
Previous sexual partner(s)	14	19	1,937	1	NS
Previous illegitimate births	3	3	0,803	1	NS
Previous termination	3	0			

Note that no statistical analysis was performed on the last variable due to the small numbers.

TABLE 40

SIGNIFICANCE OF THE RELATIONSHIP WITH REPUTED FATHER

Type of Relationship	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
(Rape	4	3)
Promiscuous relationship	7	8
Longstanding relationship	19	49

$X^2 = 2,003$ (1df); NS

Note that cases of rape were omitted from the statistical analysis.

TABLE 41

Data	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Parental involvement	13	23	0,208	1	NS

TABLE 42

SIGNIFICANCE OF SUPPORT FROM MALE PARTNER

Support from Partner	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Supportive	11	31
Not supportive	3	18
No male partner	16	11

$X^2 = 12,559$ (2df); $p < 0,01$

The significance of this variable may be accounted for by the larger number of those with supportive partners in the second sample.

TABLE 43

SIGNIFICANCE OF USE OF CONTRACEPTION

Use of Contraception	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Never used contraception	18	26
Used previously and given up	2	11
Failed contraception	4	16
(Rape	4	3
Mentally retarded	2	4)

X^2 = 4,618 (2df); NS

Note that cases of rape and mental retardation were omitted from statistical analysis.

TABLE 44

SIGNIFICANCE OF GESTATIONAL PERIOD AT PRESENTATION

Length of the Pregnancy	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Less than 12 weeks	23	41
12 or more weeks	7	19

X^2 = 0,676 (1df); NS

TABLE 45

Attitude towards the Pregnancy	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)	X^2	df	P
Ambivalent	11	19	0,224	1	NS
Accepting	10	9	4,036	1	$<$ 0,05
Denial of feelings	8	7	3,239	1	NS
Angry	12	14	2,704	1	NS
Guilty	18	25	2,694	1	NS
Hurt	8	11	0,833	1	NS

More patients were found to be accepting of their pregnancy during the period 1/3/74 - 31/5/74. This would explain the significance level of this variable.

B. Comparison between the Decisions made in the Two Population Groups, 1/3/74-31/5/74 and 1/3/75-31/5/75.

Variables in the early and late groups were examined statistically to see if there was a significant difference in the decisions made with regard to therapeutic abortion over the two periods, 1/3/74 - 31/5/74 and 1/3/75 - 31/5/75. The following tables set out some of the results.

TABLE 46

SIGNIFICANCE OF TOTAL DECISIONS MADE

Decision	1/3/74-31/5/74 (30)	1/3/75-31/5/75 (60)
Recommended	20	27
Not recommended	10	33
TOTAL	30	60

x^2 = 3,762 (1df); NS

TABLE 47

SIGNIFICANCE OF DISRUPTED FAMILY BACKGROUND

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	3	4	11	10
Absent	17	6	16	23
TOTAL	20	10	27	33

x^2 = 8,031 (3df); $p < 0,05$

The significance here may be accounted for by the fact that a larger number of patients with a disrupted family background were terminated in the later sample.

TABLE 48

SIGNIFICANCE OF A FAMILY HISTORY OF PSYCHIATRIC CARE

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	4	3	8	9
Absent	16	7	19	24
TOTAL	20	10	27	33

$x^2 = 4,402$ (3df); NS

TABLE 49

SIGNIFICANCE OF POOR SOCIALIZING ABILITY

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	10	1	10	10
Absent	10	9	17	23
TOTAL	20	10	27	33

$x^2 = 5,966$ (3df); NS

TABLE 50

SIGNIFICANCE OF A POOR SELF IMAGE

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	8	3	11	9
Absent	12	7	16	24
TOTAL	20	10	27	33

$x^2 = 3,788$ (3df); NS

TABLE 51

SIGNIFICANCE OF AGE

Age	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Under 21 years	10	2	8	10
21 years and above	10	8	19	23
TOTAL	20	10	27	33

$x^2 = 6,307$ (3df); NS

TABLE 52

SIGNIFICANCE OF ETHNIC GROUP

Ethnic Group	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
White	13	6	17	30
Black	7	4	10	3
TOTAL	20	10	27	33

$x^2 = 8,106$ (3df); $p < 0,05$

More White patients were refused termination in the second sample, which appears to account for the significance level.

TABLE 53

SIGNIFICANCE OF SOCIAL ECONOMIC CLASS

Social Economic Class	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Social classes I, II and III	12	6	15	19
Social classes IV, V and VI	8	4	12	14
TOTAL	20	10	27	33

$x^2 = 3,879$ (3df); NS

TABLE 54

SIGNIFICANCE OF MARITAL STATUS

Marital Status	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Unmarried	18	6	14	25
Married, divorced or separated	2	4	13	8
TOTAL	20	10	27	33

$x^2 = 12,988$ (3df); $p < 0,01$

The significance here may be accounted for by the fact that more unmarried patients fall within the not termination group and more married, divorced or separated patients fall in the recommended group of the second period.

TABLE 55

SIGNIFICANCE OF EDUCATIONAL LEVEL

Educational Level	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
No education Primary school High school	13	7	18	23
University	7	3	9	10
TOTAL	20	10	27	33

$x^2 = 3,778$ (3df); NS

TABLE 56

SIGNIFICANCE OF PREVIOUS SEXUAL PARTNER(S)

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	8	6	6	13
Absent	12	4	21	20
TOTAL	20	10	27	33

$x^2 = 6,734$ (3df); NS

Note that although the variable, previous sexual partner(s) was not statistically significant, more patients with previous sexual partners in the first period fell in the termination group, while in the second sample this was reversed.

TABLE 57

SIGNIFICANCE OF RELATIONSHIP WITH REPUTED FATHER

Type of Relationship	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
(Rape	4	0	3	0)
Promiscuous relationship	7	0	5	3
Longstanding relationship	9	10	19	30
TOTAL	20	10	27	33

$X^2 = 6{,}189$ (3df); NS

Note that cases of rape were omitted from statistical analysis.

TABLE 58

SIGNIFICANCE OF PARENTAL INVOLVEMENT

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	11	2	10	13
Absent	9	8	17	20
TOTAL	20	10	27	33

$X^2 = 6{,}433$ (3df); NS

Although not significant, more patients whose parents were involved were terminated in the first period, whereas this was reversed during the second period.

TABLE 59

SIGNIFICANCE OF SUPPORT FROM THE MALE PARTNER

Support from Partner	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Male partner supportive	5	6	13	18
Male partner not supportive / No male partner	15	4	14	15
TOTAL	20	10	27	33

$X^2 = 6{,}703$ (3df); NS

TABLE 60

SIGNIFICANCE OF THE USE OF CONTRACEPTION

Use of Contraception	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Never used contraception	9	9	8	18
Used previously and given up / Failed contraception	5	1	13	14
(Rape	4	0	3	0
Mentally retarded	2	0	3	1)
TOTAL	20	10	27	33

$X^2 = 8{,}109$ (3df); $p < 0{,}005$

Note that cases of rape and mental retardation were omitted from statistical analysis. More patients with either failed contraception or who had used contraception previously and had given it up fell within the not recommended group of the second period.

TABLE 61

SIGNIFICANCE OF GESTATIONAL PERIOD AT INITIAL PRESENTATION

Length of Pregnancy	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Under 12 weeks	18	5	19	22
12 weeks and over	2	5	8	11
TOTAL	20	10	27	33

$X^2 = 7{,}403$ (3df); NS

TABLE 62

SIGNIFICANCE OF DENIAL OF THE PREGNANCY

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	8	0	4	3
Absent	12	10	23	30
TOTAL	20	10	27	33

X^2 = 8,764 (3df); $p < 0,05$

The significance here may be accounted for by the fact that more patients expressing feelings of denial towards the pregnancy fell in the termination group of the first period.

TABLE 63

SIGNIFICANCE OF FEELINGS OF ANGER

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	8	4	6	8
Absent	12	6	21	25
TOTAL	20	10	27	33

X^2 = 6,433 (3df); NS

TABLE 64

SIGNIFICANCE OF FEELINGS OF GUILT

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	11	7	11	14
Absent	9	3	16	19
TOTAL	20	10	27	33

X^2 = 6,670 (3df); NS

TABLE 65

SIGNIFICANCE OF FEELINGS OF HURT

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	6	2	5	6
Absent	14	8	22	27
TOTAL	20	10	27	33

x^2 = 4,705 (3df); NS

TABLE 66

SIGNIFICANCE OF FEELINGS OF ACCEPTANCE

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	3	3	3	6
Absent	17	7	24	27
TOTAL	20	10	27	33

x^2 = 4,454 (3df); NS

TABLE 67

SIGNIFICANCE OF FEELINGS OF AMBIVALENCE

	1/3/74-31/5/74 (30)		1/3/75-31/5/75 (60)	
	Term	Not Term	Term	Not Term
Present	5	6	3	16
Absent	15	4	24	17
TOTAL	20	10	27	33

x^2 = 5,816 (3df); NS

The results shown in this chapter are of particular interest as they express a consistency in decision making, even though two distinct periods are covered - that of prior to and just after the passing of the Abortion and Sterilization Act 2/75.

CHAPTER 10

RESULTS FROM FOLLOW-UP DATA

A. METHOD OF FOLLOW-UP

An attempt was made to follow up all patients who had initially presented. Contact was made either telephonically or by letter and personal appointments were made wherever possible. Follow-up was conducted between 12 and 18 months after the patient's initial presentation for assessment. 104 Patients were seen personally. Thirteen who lived far away from the hospital sent written replies expressing their feelings about the abortion procedure and decision made, and what had happened since the initial assessment. Twenty-two patients responded to a telephonic interview, but did not wish to be seen personally. Collateral data was collected on a further 23 patients, sources being either a relative, friend, social agency or general practitioner. No information was available on 34 patients. A follow-up on 80% of the original sample was achieved, despite the difficulties. Patients seeking an abortion are inclined to resist enquiry of this kind, e.g. in some instances, up to six contacts were needed before a response could be elicited.

B. RESULTS GAINED FROM QUESTIONNAIRE ON EMOTIONAL RESPONSES

A total of 105 patients completed the questionnaire on immediate and long-term emotional reactions relating to the abortion decision. The emotional responses examined were depression, relief, regret, embarrassment, guilt, anxiety, shame, fear of disapproval, anger, happiness, doubt, disappointment in self and denial of feelings. Each patient completed a questionnaire on her feelings about the pregnancy at the time of initial presentation as she remembered them, and her present feelings about either the abortion or other fate of the pregnancy. The fallability of the retrospective reactions is appreciated. The responses were rated from

1 - 5 according to their intensity, i.e. 1 meaning that the feeling was not present at all, whereas 5 meant a considerable degree of that response.

Seventy-seven of those patients who completed the questionnaire had obtained an abortion either legal, illegal or self-induced, while the remaining 28 had not. Some of the results of the total sample of 105 follow (raw scores for this data are given in Appendix L).

(i) Long-Term Reaction to the Abortion versus Long-Term Reaction to Refusal to Recommend Abortion

Comparing the two groups, there were no statistically significant differences in the degree of emotional reactions as regards depression, regret, embarrassment, guilt, anxiety, shame, fear of disapproval, anger, happiness, disappointment in self and denial of feelings. Notable differences however, were observed in the areas of relief and doubt.

TABLE 68

RELIEF

	1	2	3	4	5
Aborted	8	3	6	11	49
Not aborted	4	10	1	2	11

$X^2 = 20{,}588$ (4df); $p < 0{,}001$

TABLE 69

DOUBT

	1	2	3	4	5
Aborted	54	11	5	1	6
Not aborted	12	5	7	2	2

$X^2 = 11{,}22$ (4df); $p < 0{,}02$

(See Appendix L for remaining tables).

(ii) Immediate Reaction versus Long-Term Reaction of those who were Aborted

Comparing the responses of relief, regret, guilt, anxiety, shame, fear of disapproval, anger, happiness, doubt, disappointment in self and denial of feelings in the immediate and long-term reaction to abortion in this group, no differences were found. However, depression and embarrassment were both found to be significantly different.

TABLE 70

DEPRESSION

	1	2	3	4	5
Immediate reaction	23	14	15	7	18
Long-term reaction	52	14	5	3	3

$X^2 = 28,527$ (4df); $p < 0,001$

TABLE 71

EMBARRASSMENT

	1	2	3	4	5
Immediate reaction	34	14	8	9	12
Long-term reaction	54	13	2	2	6

$X^2 = 14,637$ (4df); $p < 0,01$

(See Appendix L for remaining tables).

(iii) Immediate Reaction versus Long-Term Reaction of those not Terminated

Comparing the reactions of relief, regret, embarrassment, guilt, anxiety, shame, fear of disapproval, anger, happiness, doubt, disappointment in self and denial of feelings, there was no measurable significance in the immediate and long-term reactions to refusal of abortion. However, depression was found to be significant.

TABLE 72

DEPRESSION

	1	2	3	4	5
Immediate reaction	6	8	3	4	7
Long-term reaction	20	3	2	0	3

$x^2 = 15,611$ (4df); $p < 0,01$

(See Appendix L for remaining tables).

Further statistical analysis was conducted on a corrected sample of 97 patients, omitting those who were pregnant as the result of rape. The sample was divided into those who had been recommended therapeutic abortion on psychiatric grounds and those who had not been recommended, although they may have subsequently obtained an abortion illegally, abroad or by self-induction. Complete results are given in the following tables which show firstly, the immediate reaction to the decision given retrospectively and secondly, the long-term reaction to the decision ascertained at follow-up.

(iv) Immediate Reaction to the Decision made, given Retrospectively

In comparing the immediate reaction of those recommended and those not recommended for therapeutic abortion, as given retrospectively, there were significant differences between the two groups with regard to the reactions of relief, regret, guilt, anxiety and happiness.

TABLE 73

RELIEF

	1	2	3	4	5	Total
Not recommended	9	11	6	3	10	39
Recommended	6	4	3	9	36	58
TOTAL	15	15	9	12	46	97

$x^2 = 19,592$ (4df); $p < 0,0006$

TABLE 74

REGRET

	1	2	3	4	5	Total
Not recommended	12	7	4	10	6	39
Recommended	38	7	6	5	2	58
TOTAL	50	14	10	15	8	97

$X^2 = 14,418$ (4df); $p < 0,0061$

TABLE 75

GUILT

	1	2	3	4	5	Total
Not recommended	14	2	7	9	7	39
Recommended	25	13	4	5	11	58
TOTAL	39	15	11	14	18	97

$X^2 = 10,708$ (4df); $p < 0,03$

TABLE 76

ANXIETY

	1	2	3	4	5	Total
Not recommended	5	8	8	7	11	39
Recommended	21	14	12	6	5	58
TOTAL	26	22	20	13	16	97

$X^2 = 11,322$ (4df); p 0,02

TABLE 77

HAPPINESS

	1	2	3	4	5	Total
Not recommended	15	6	7	4	7	39
Recommended	7	12	8	13	18	58
TOTAL	22	18	15	17	25	97

$X^2 = 11,292$ (4df); $p < 0,0235$

(v) Long-Term Reaction to the Decision made Given at Follow-Up

In comparing the long-term reactions of those recommended and those not recommended, there were significant differences between the two groups with regard to the reactions of regret, relief and doubt.

TABLE 78

REGRET

	1	2	3	4	5	Total
Not recommended	20	11	5	0	3	39
Recommended	44	3	6	2	3	58
TOTAL	64	14	11	2	6	97

$X^2 = 12,417$ (4df); $p < 0,0145$

TABLE 79

RELIEF

	1	2	3	4	5	Total
Not recommended	6	11	3	4	15	39
Recommended	5	2	4	8	39	58
TOTAL	11	13	7	12	54	97

$X^2 = 15,331$ (4df); $p < 0,0041$

TABLE 80

DOUBT

	1	2	3	4	5	Total
Not recommended	19	6	9	2	3	39
Recommended	42	9	2	1	4	58
TOTAL	61	15	11	3	7	97

$X^2 = 10,899$ (4df); $p < 0,0277$

(See Appendix L for remaining tables).

DISCUSSION

In the sample of 105 patients who completed the questionnaire, there was found to be a significant difference between the long-term reaction to abortion versus the long-term reaction to refusal of abortion in the areas of relief and doubt. Not surprisingly, patients who had been terminated experienced a far greater sense of relief than those who had not been terminated, and also asserted that they had had little doubt that the correct decision had been made.

In comparing the immediate and long-term reactions of those terminated, significant differences in depression and embarrassment were found. More patients reported no feelings of depression at follow-up by comparison with their initial reactions as recalled retrospectively.

In comparing the immediate and long-term reactions of those not terminated, depression was also found to be significantly different. This could also be accounted for by a lessening of feelings of depression with time.

In the corrected sample of 97 patients, the following emotional reactions were found to be significant in comparing the retrospective reactions to the decision to terminate or not - relief, regret, guilt, anxiety, happiness. All patients recommended for therapeutic abortion experienced greater feelings of relief and happiness, and least regret about the decision, compared with those not recommended for therapeutic abortion. These in turn experienced greater sensations of guilt and anxiety. There was found to be no significant difference between the two groups in feelings of depression, embarrassment, shame, fear of disapproval, anger, doubt, disappointment in self and denial of feelings as considered retrospectively.

In the corrected sample of 98, in comparing the long-term reactions given at follow-up, emotional factors found

to be significant were those of regret, relief and doubt. Most of those patients who had been terminated had no feelings of regret or doubt, and had a greater feeling of relief than those not terminated. No significant difference was found between the two groups in relation to the emotional factors of depression, embarrassment, guilt, anxiety, shame, fear of disapproval, anger, happiness, disappointment in self and denial of feelings.

C. FOLLOW-UP DATA ON DEMOGRAPHIC AND PSYCHO-SOCIAL FACTORS

(i) Outcome of the Pregnancy

TABLE 93

Outcome of the Pregnancy	Termination Recommended	Termination Refused
Original total	107	90
No. contacted at 12-18 mths	88 (82%)	69 (78%)
Data at 12-18 mths	107 (100%)	69 (78%)
Pregnancy to term	5	38
Adoption	?	6
Baby kept	?	32
Two parent family		(18)
One parent family		(14)
Further pregnancy	3	-
Repeat termination	1	0
To term		2

An attempt was made to recontact all of the 197 original patients who presented. At follow-up, 88 of those recommended and 69 of those refused therapeutic abortion were contactable. Additional data was available through medical records on those patients who were not traceable but who had been granted termination, thus allowing for a 100% follow-up rate on this group. It is of interest to note that although 107 patients were recommended for therapeutic abortion on psychiatric

grounds, five of these patients decided to go through to term. Also of interest is the fact that three of the 107 patients recommended, 2,8% of that group, had presented for a repeat termination prior to the follow-up 12 - 18 months after initial presentation. Out of 69 patients refused abortion, just over half (38) actually went through to term.

TABLE 94

Outcome of the Pregnancy (cont)	Termination Recommended	Termination Refused
Original total	107	90
No. contacted at 12-18 mths	88 (82%)	69 (78%)
Data at 12-18 mths	107 (100%)	79 (78%)
Legal termination		
Psychiatric	95	0
Medical	-	3
Private (prior to Act 2/75)	-	3
'Overseas'	-	8
'Miscarriage'	6	11
Illegal abortion		
Attempted - not successful	-	9
Attempted - successful	1	6

Of a total of 107 patients recommended for therapeutic abortion on psychiatric grounds, 95 underwent the procedure with one patient preferring to seek illegal means. Table 94 clearly shows the balance of the 69 refused terminations and what became of their pregnancies. Fourteen of these patients gained 'legal' abortions elsewhere, while six sought and gained illegal terminations of pregnancy. The term 'mis-carriage' is in quotes since it is doubtful whether the larger proportion of reported 'miscarriages' in the not termination group were all spontaneous.

(ii) Mental Health Outcome at 12-18 Months

TABLE 95

Follow-up Data	Termination Group	Not Termination Group
Totals	88	69
Suicide	0	0
Attempted suicide	0	3
Psychiatric treatment	12	6
Increased use of alcohol, tobacco, dagga	10	5
Increased use of tranquillizers	13	8
Adverse personality change	13	7
Greater social isolation	6	1

It is important to note that although no patients committed suicide, three of those refused termination made a suicide attempt. A total of 18 patients had or were receiving psychiatric treatment, either since the initial presentation or at follow-up. Two-thirds of these patients fell within the termination group. A larger number of patients falling within the termination group reported increased use of alcohol, tobacco, dagga and tranquillizers, adverse personality change and greater social isolation. These findings are appropriate in view of the fact that those patients granted termination on psychiatric grounds are considered to be those who are more vulnerable to life's stresses.

(iii) Further Results Gained from the Follow-up

A corrected sample of 135 patients, 72 of whom were recommended and 69 of whom were not recommended for therapeutic abortion, was submitted to statistical analysis. Some of the results follow.

TABLE 96

SUPPORT FROM PARENTS

	Not Supportive	Supportive	Not Applicable	Total
Not terminated	19	41	3	63
Terminated	36	36	0	72
TOTAL	55	77	3	135

$x^2 = 8{,}014;\ p < 0{,}018$

It is interesting to note here that more of those in the not termination group reported parental support.

TABLE 97

SUPPORT FROM REPUTED FATHER

	Not Supportive	Supportive	Total
Not terminated	27	36	63
Terminated	33	39	72
TOTAL	60	75	135

$x^2 = 0{,}03$ (1df); NS

Support from the reputed father was reported as having been present in over half of those patients falling in both the termination and not termination groups.

TABLE 98

SUPPORT FROM PEERS

	Not Supportive	Supportive	Not Applicable	Total
Not terminated	20	40	3	63
Terminated	45	27	0	72
TOTAL	65	67	3	135

$x^2 = 14{,}602$ (2df); $p < 0{,}0007$

The significant level in this variable appears to be accounted for by the large number of patients who were terminated who reported a lack of support from their peer group.

TABLE 99

	Not Left Alone	Left Alone	Total
Not terminated	54	9	63
Terminated	60	12	72
TOTAL	114	21	135

X^2 = 0,02 (1df); NS

Important to note here is that 21 of the 135 patients, 15,5%, reported being left alone to cope with the termination or pregnancy, and that more of these fell within the termination group.

TABLE 100

CHANGE IN ATTITUDE TOWARDS THERAPEUTIC ABORTION AT FOLLOW-UP

	Anti-Abortion	Pro Abortion (Not on Demand)	Pro Abortion (On Demand)	Attitude Changed	Total
Not terminated	13	38	5	7	63
Terminated	7	53	6	6	72
TOTAL	20	91	11	13	135

X^2 = 3,857 (3df); NS

13 Patients admitted to a change in attitude towards therapeutic abortion. 20 Patients, 13 of whom were not terminated, were anti-abortion while only 11 patients felt abortion should be permitted 'on demand'.

TABLE 101

USE OF CONTRACEPTION SINCE INITIAL PRESENTATION

	Not Used Since Birth or Abortion	Used Since Birth or Abortion	Erratic Use	N/A	Total
Not terminated	9	49	1	4	63
Terminated	16	37	5	14	72
TOTAL	25	86	6	18	135

$x^2 = 11,306$ (3df); $p < 0,01$

Not applicable applies to those patients who were sterilized either after the termination or after birth. The significance of this variable seems to be accounted for by the large number of patients who used contraception since either the abortion or birth.

TABLE 102

STILL INVOLVED WITH REPUTED FATHER AT FOLLOW-UP

	No Longer Involved	Still Involved	Total
Not terminated	32	31	63
Terminated	38	34	72
TOTAL	70	65	135

$x^2 = 0,003$ (1df); NS

In both groups just over half of the patients were no longer involved with the reputed father at follow-up.

TABLE 103

ENGAGED OR MARRIED TO REPUTED FATHER AT FOLLOW-UP

	Engaged or Married	Not Engaged or Married	Total
Not terminated	22	41	63
Terminated	25	47	72
TOTAL	47	88	135

$x^2 = 0,024$ (1df); NS

It is interesting to note that although there is no significant difference between the two groups, more patients falling within the termination group, as opposed to those in the not termination group, were found to be either engaged or married to the reputed father at follow-up.

TABLE 104

SUCCESSFUL RELATIONSHIP WITH REPUTED FATHER AT FOLLOW-UP

	Not Successful	Successful	N/A	Total
Not termination	5	26	32	63
Termination	7	27	38	72
TOTAL	12	53	70	135

x^2 = 0,267 (2df); NS

Of the 65 patients who reported that they were still involved with the reputed father, whether or not engaged or married, 53 described their relationship as 'successful'. Those patients falling in the N/A category are those who were no longer associating with the reputed father at follow-up.

TABLE 105

ENGAGED OR MARRIED TO SOMEONE ELSE AT FOLLOW-UP

	Engaged or Married	Not Engaged or Married	Total
Not termination	5	58	63
Termination	6	66	72
TOTAL	11	124	135

x^2 = 0,053 (1df); NS

Only 11 patients out of 70 patients who were no longer involved with the reputed father, were found to be engaged or married to someone else at follow-up. Out of these 11 patients, all but one had told their new partner about the birth or abortion.

TABLE 106

DATING CASUALLY WITH SEXUAL INTERCOURSE AT FOLLOW-UP

	No	Yes	N/A	Total
Not terminated	21	13	29	63
Terminated	33	9	30	72
TOTAL	54	22	59	135

X^2 = 2,823 (2df); NS

At follow-up 22 patients admitted to having been dating casually with sexual intercourse since the birth or termination.

TABLE 107

STEADY BOYFRIEND WITH SEXUAL INTERCOURSE AT FOLLOW-UP

	No	Yes	N/A	Total
Not terminated	23	11	29	63
Terminated	24	18	30	72
TOTAL	47	29	59	135

X^2 = 1,132 (2df); NS

A total of 29 patients stated that they had a steady boy friend with sexual intercourse at follow-up.

TABLE 108

PLATONIC RELATIONSHIPS ONLY AT TIME OF FOLLOW-UP

	No	Yes	N/A	Total
Not terminated	26	11	26	63
Terminated	27	15	30	72
TOTAL	53	26	56	135

X^2 = 0,321 (2df); NS

At follow-up 26 patients reported that they had only been associating with the opposite sex on a platonic level since either the birth or termination.

TABLE 109

WARY OF MEN SINCE PREGNANCY

	No	Yes	Total
Not terminated	43	20	63
Terminated	44	28	72
TOTAL	87	48	135

$X^2 = 0{,}468$ (1df); NS

Out of a total of 135 patients, just over one-third, 48 patients, reported that at the time of follow-up they felt more wary of men than they were before.

TABLE 110

PARENTAL KNOWLEDGE OF THE PREGNANCY

	No	Yes	Total
Not terminated	18	45	63
Terminated	35	37	72
TOTAL	53	82	135

$X^2 = 4{,}849$ (1df); $p < 0{,}027$

The significance of this variable may be accounted for by the fact that more of those not terminated confided in their parents about the pregnancy. Taking the total sample into consideration, over half of these parents were aware of the pregnancy and abortion.

TABLE 111

SIBLINGS' KNOWLEDGE OF THE PREGNANCY

	No	Yes	N/A	Total
Not terminated	18	43	2	63
Terminated	38	31	3	72
TOTAL	56	74	5	135

X^2 = 8,727 (2df); $p < 0,012$

The significance level of this variable, again, may be accounted for by the fact that many more siblings of those not terminated were aware of the situation.

TABLE 112

PARENTAL ACCEPTANCE THROUGHOUT

	No	Yes	N/A	Total
Not terminated	4	42	17	63
Terminated	4	34	34	72
TOTAL	8	76	51	135

X^2 = 5,935 (2df); $p < 0,05$

This table illustrates the fact that the vast majority of parents in both groups were considered to be accepting of the situation.

TABLE 113

SIBLING ACCEPTANCE THROUGHOUT

	No	Yes	N/A	Total
Not terminated	3	40	20	63
Terminated	3	27	42	72
TOTAL	6	67	62	135

X^2 = 9,772 (2df); $p < 0,007$

A larger number of the siblings of the presenting patients were not aware of the situation; however, of those who were, most were accepting of the patient.

TABLE 114

ACCEPTANCE BY REPUTED FATHER

	No	Yes	N/A	Total
Not terminated	24	36	3	63
Terminated	26	39	7	72
TOTAL	50	75	10	135

$X^2 = 1,205$ (2df); NS

Just over half of the patients from both groups reported that the reputed father had been supportive.

TABLE 115

CHANGE IN PEER GROUP REPORTED AT FOLLOW-UP

	No Change	Change	Total
Not terminated	56	7	63
Terminated	57	15	72
TOTAL	113	22	135

$X^2 = 1,67$ (1df); NS

At follow-up only 22 patients reported having changed their peer group association since either the birth or abortion.

TABLE 116

WITHDRAWN, ANTI-SOCIAL AND ISOLATED INITIALLY

	No	Yes	Total
Not terminated	45	18	63
Terminated	40	32	72
TOTAL	85	50	135

$X^2 = 2,981$ (1df); NS

Over one-third of the sample of 135 patients reported being withdrawn, anti-social and isolated initially. Two-thirds of this group of 50 were from the termination group.

TABLE 117

PATIENT FELT THAT THE DOCTOR HAD MADE THE CORRECT DECISION

	No	Yes	Uncertain	Total
Not terminated	18	33	12	63
Terminated	0	61	11	72
TOTAL	18	94	23	135

X^2 = 25,898 (2df); $p < 0,00001$

None of those recommended for termination felt the wrong decision had been made, although 11 were uncertain. It is interesting to note that two-thirds of those not terminated also agreed with the decision at follow-up.

TABLE 118

RELIGIOUS CHANGE ADMITTED AT FOLLOW-UP

	Change	No Change	Total
Not termination	2	61	63
Termination	8	64	72
TOTAL	10	125	135

X^2 = 2,037 (1df); NS

At follow-up only 10 patients reported a change in religious attitude with eight of these falling within the termination group.

TABLE 119

ATTITUDES TO THE CONTINUED PREGNANCY (AT FOLLOW-UP)

Total to term of those not recommended		38
Negative Attitudes		
Disgusted	4	
Guilty	16	
Angry	8	
Ashamed	16	
Positive Attitudes		
Accepting	31	
Maternal	29	

At follow-up patients were asked about their attitude towards the continued pregnancy. These attitudes were divided into those considered positive and those considered negative, as shown in Table 119. Although there is an overlap of feelings between the two categories, it may be seen that the predominant attitudes towards the continued pregnancy were the positive ones of acceptance and feeling maternal.

CHAPTER 11

DISCUSSION OF THE RESULTS

A. DISCUSSION OF THE RESULTS FROM THE PRESENT STUDY

(i) Initial Presentation Data

Hypothesis number one postulated that "even if there are no data which can accurately predict the risk of potential permanent damage to a woman's mental health of a continued pregnancy, nevertheless factors customarily considered 'psychiatric' influence the decisions made about its termination on psychiatric grounds." Separate variables used to test this hypothesis included disrupted family background, family history of psychiatric care, the patient herself being an illegitimate, adopted or a fostered child, behaviour/academic difficulties at school, poor socializing ability, work record, poor self-image, previous psychiatric treatment, previous suicide attempt, threats of suicide if refused termination, threats of illegal abortion if refused termination, and referral for psychiatric treatment as a result of the interview for assessment for therapeutic abortion.

Examining the variables in the two groups of patients, no significant difference was found in the following - disrupted family background, family history of psychiatric care, the patient herself being an illegitimate, adopted or a fostered child, behaviour/academic difficulties at school, poor socializing ability, work record, poor self-image, previous psychiatric treatment, previous suicide attempt, threats of suicide if refused termination and threats of illegal abortion if refused termination. Similar results were obtained when the amended sample of 168 patients was submitted to statistical analysis. The only variable found to be significant was that of the patient being referred for psychiatric treatment as a result of the interview for assessment for therapeutic abortion. A significant result was obtained from both the total and corrected samples in respect of this variable.

The above results illustrate the fact that considering

each contributing variable separately, the 'psychiatric' data of a patient's past history did not appear to influence the decision made. Nevertheless, such information certainly contributed to the judgment that the individual was in need of psychiatric treatment, and probably weighed in favour of a positive decision to terminate in a few cases. However, it appeared that the decision was based more on the patient's present mental state and present ability to withstand stress rather than on past evidence. This is also borne out by the fact that 2/3rds of those patients with documented previous and/or current psychiatric disorder were not terminated, while all those with newly diagnosed psychiatric disorder were recommended for therapeutic abortion. All those diagnosed as 'adolescent turmoil' were refused abortion, while many of those diagnosed as falling within the major diagnostic categories, e.g. mental retardation, psychosis and neurotic depression, were recommended for termination.

Hypothesis number two stated that "given a pregnancy which is thought to constitute a serious threat to the mental health of the mother, if measurable criteria cannot be specified before a decision is made by a psychiatrist, then factors other than those customarily considered 'psychiatric' are likely to influence the decision made, viz. 'psycho-social factors'" Variables tested under this hypothesis included age, ethnic group, social-economic class, marital status, parity, educational level, previous sexual partner(s), previous illegitimate births, previous termination, relationship with the reputed father, parental involvement and support from the reputed father.

Variables considered to be significant in both the total and amended samples included social-economic class, marital status, previous illegitimate births, previous termination and parental involvement. Of particular note here is the fact that social-economic class, previous illegitimate births and previous termination did not appear to weight the abortion decision.

Ethnic group, educational level, relationship with and support from the reputed father were all found to be significantly different in the two groups when considered in the total sample, but not in the amended sample. The total sample included patients with mental retardation, of limited education, many of whom had been subjected to rape. Termination of the unwanted pregnancy was permitted under the rubric of the Immorality Act 23/57.

Of interest is the fact that the variables of age, parity and previous sexual partner(s) were found to be significantly different in the two groups. The significance of age weighted in favour of termination for those under the age of 16 years and those over the age of 30 years and may be partly accounted for by the fact that the Abortion and Sterilization Bill of 1973, which covered pregnant girls under the age of 16 years, was used as a guideline in the initial stages of the study. The significance of parity suggests that the possible long-term adverse effect on the mental health of a multiparous mother rearing an unwanted child, may have been taken into account. This might also account for the larger number of patients over the age of 30 years that were granted termination. In the discriminant analysis, more than one intimate relationship, which weighted against therapeutic abortion, emerged as one of the main factors in the decision whether or not to recommend termination. This could either reflect a bias against the patient who was considered irresponsible, or was part of a pattern of behaviour reflecting a personality disorder which of itself was insufficient grounds for termination.

From the above data it may be concluded that non-psychiatric or psycho-social data appeared to influence the recommendations made in the abortion decision.

Hypothesis number three stated that "attitudes to contraception and unwanted pregnancy on the part of the patient and/or her family contributed to a decision not to terminate a pregnancy on psychiatric grounds." The findings in the

two groups refuted this hypothesis. Anger, guilt and hurt were almost equally found in members of both groups, but ambivalence about the pregnancy and/or abortion seemed to weight against a decision to recommend termination. Acceptance and denial were found to be significant in the total sample, with the former appearing to weight against a decision to terminate, while the latter appeared to weight in favour of a termination. However, both were found to be not significant in the amended sample. Thus, it may be said that the patient's attitude towards the pregnancy and/or abortion, particularly feelings of ambivalence, could have contributed to a decision not to terminate a pregnancy on psychiatric grounds.

In order to examine the consistency of decision making, the data from patients assessed early in the study 1/3/74 - 31/5/74 were compared with another group a year later over a similar three month period. Differences were found in the two samples, but not in the variables disrupted family background, family history of psychiatric disorder, poor socializing ability and previous psychiatric treatment, that could influence a psychiatric decision. This is of relevance in considering the different wording of the Abortion and Sterilization Bill of 1973 and the Abortion and Sterilization Act 2/75 under which the two population groups were referred for assessment.

Comparison between the decisions made in the two population groups isolated the variables of disrupted family background, ethnic group, marital status, parity, use of contraception and denial of the pregnancy as significant. A larger percentage of those seen in the 1/3/75 - 31/5/75 period were considered to come from disrupted family backgrounds, 35% of that total as against 3% of the total referred during the 1/3/74 - 31/5/74 period. More of these patients had terminations recommended during 1/3/75 - 31/5/75. In both periods, fewer Black than White patients were seen, although in both instances more Black than White patients were recommended for therapeutic abortion, with the percentage of

those being recommended being statistically significant in the second time period. More unmarried than divorced, separated or married patients were seen in both periods. The statistical significance of this variable seems to be accounted for by the fact that in the period 1/3/74 - 31/5/74 more unmarried patients were recommended than not recommended for therapeutic abortion, whereas in the period 1/3/75 - 31/5/75 this was reversed with more unmarried patients being refused. With regard to the significance of parity, more nulliparous patients were recommended than not recommended during 1/3/74 - 31/5/74, whereas during 1/3/75 - 31/5/75 more nulliparous patients were refused. The significance of the use of contraception appears to be accounted for by the fact that an equal number of patients who had never used contraception were granted and refused therapeutic abortion during 1/3/74 - 31/5/74, whereas 2/3rds of these patients were refused termination during 1/3/75 - 31/5/75. All of those patients showing an attitude of denial towards the pregnancy during the first period were recommended for therapeutic abortion.

There was found to be no significant difference in the decisions made during the two time periods when the statistical variables of a family history of psychiatric care, poor socializing ability, poor self-image, age, social-economic status, educational level, previous sexual partner(s), type of relationship with the reputed father, parental involvement, support from the male partner, gestational period at the time of presentation and attitudes towards the pregnancy of anger, guilt, hurt, acceptance and ambivalence, were submitted to statistical analysis. Discriminant analysis of the total sample of 197 patients showed that the main factors in the decision to terminate or not were referral for psychiatric treatment after the interview, evidence of ambivalence over the pregnancy, and/or abortion, and more than one intimate relationship. The fact that none of these three variables proved to be significant determinants of the decisions made when comparing the two periods 1/3/74 -

31/5/74 and 1/3/75 - 31/5/75, tends to illustrate the fact that a consistent policy was maintained even though changes in the law had been made.

(ii) Follow-up Data

At follow-up, emotional factors examined in relation to the abortion or pregnancy were those of depression, relief, regret, embarrassment, guilt, anxiety, shame, fear of disapproval, anger, happiness, doubt, disappointment in self and denial of feelings. In comparing the long-term reaction to abortion and the long-term reaction to the refusal of abortion, the emotional factors of relief and doubt were both found to be significant, with those patients who were aborted experiencing far greater relief and considerably less doubt than those who were refused therapeutic termination of pregnancy. In comparing the immediate reaction and the long-term reaction of those terminated, depression and embarrassment emerged as significant factors, in each case these reactions being more pronounced early on, but receding over time. In comparing the immediate reaction and the long-term reaction of those not terminated again depression emerged as a significant factor with depression lessening over time. The above results relate to the total sample of 105 patients who participated in sharing their emotional feelings towards the pregnancy and/or abortion at follow-up.

Further data on the amended sample of 97 patients was submitted to statistical analysis comparing the emotional reaction of those recommended and those not recommended for therapeutic abortion at the time of the initial decision, as remembered, with those experienced at the time of interview on follow-up. Examining the initial reactions to the abortion decision as given retrospectively, feelings of relief, regret, guilt, anxiety and happiness were found to be significant. Feelings of relief and happiness were more prevalent amongst those recommended, while those of guilt, anxiety and regret were more prominent amongst those not recommended for therapeutic abortion. It is of interest to

note that there was no statistical difference between the two groups with regard to feelings of depression, embarrassment, shame, fear of disapproval, anger, doubt, denial and disappointment in self. In comparing the long-term emotional reaction as given at follow-up. a statistical significance emerged between the two groups with regard to regret, relief and doubt. More patients in the recommended group felt neither regret nor about the decision made, and instead admitted to greater sensations of relief than those not recommended for therapeutic abortion. No differences were found as regards depression, embarrassment, guilt, anxiety, shame, fear of disapproval, anger, happiness, denial nor disappointment in self. The most noteworthy factor in these results from the psychiatric point of view, is the fact that in the long-term follow-up, no differences were found with regard to depression, guilt and anxiety.

Outcome of the Pregnancy

At follow-up 12-18 months after initial presentation, data was obtained on 100% of the group recommended for therapeutic abortion. 82% of this group of 107 patients had been contacted personally. Ninety-five patients of the total had undergone a therapeutic abortion as advised, while six patients reported a 'miscarriage' after recommendation, but prior to the abortion procedure. A further five patients were not terminated and went through to term, while one patient underwent an illegal abortion.

An example of one of the patients recommended for therapeutic abortion but who decided to go through to term is the following. Aletta presented as an 18 year old Coloured female, a trainee teacher, and 11 weeks pregnant. The gynaecological report expressed the fact that she was markedly depressed and had been impregnated by an irresponsible, immature man. At the time of presentation, Aletta felt she was unable to accept the responsibilities of motherhood. Further investigation into the family showed that the patient was the eldest of five siblings and the

most successful, academically, of a working class family. Her father was extremely strict. On hearing about the pregnancy, he completely withdrew from the patient while her mother, who played a less prominent role in family life, had reacted to the pregnancy by becoming 'hysterical'. The patient had had a brief relationship with the reputed father whom she never informed about the pregnancy and about whom she had learnt that a court case was pending relating to his sexual interference with two schoolboys, and that he had a living child from a previous union. The patient was ambivalent about the pregnancy, worrying firstly that she would be rejected by her family, and secondly wishing to continue with her studies at teachers' training college. The opinion of the psychiatric consultant was as follows. "I think that termination should be performed on psychiatric grounds. If this is not done, the patient would go on with the pregnancy (not seek an illegal abortion); marriage with the man responsible would not take place; she would abandon her teaching career and be castigated by her family. The net result of these events, in my opinion, would have a permanent and serious ill effect on the future mental health of this sensitive and rather vulnerable girl." Due to the patient's ambivalence, a further interview was held with the patient and her parents. Here it became clear that it was under parental duress that the patient was requestion abortion. At this point the patient decided to go ahead with the pregnancy. At follow-up Aletta expressed relief that she had continued to term and kept her baby. She had remained at home throughout and her parents appeared to have accepted the situation. She was coping adequately with her baby, and had resumed her studies. She had broken off her relationship with the reputed father, but was receiving regular maintenance from him. She stated that she was still pro-abortion 'but under strict conditions' and felt that she herself could never go through such an operation. She felt that her experience had matured her and that she felt very happy and contented with her baby.

Do those granted a termination become pregnant again? At follow-up of the original total of 107 patients who had presented and been granted therapeutic abortion, three reported a further pregnancy with or without an attempt at abortion. An example of such repeat pregnancies is Christine. This patient first presented at age 23 years and 10 weeks pregnant. She was at that time studying for her degree by correspondence and doing part-time work. She was referred by the gynaecologist because she had strong 'conscientious objections' to having children. From her history it seemed that she had great difficulty with all interpersonal relationships, as well as with organizing her life and in coming to terms with her present situation. She had poor relationships with both her parents and her siblings, seeing them only infrequently. She had a variety of gynaecological complaints which nullified attempts to place her on reliable contraceptive devices. She had had a number of sexual relationships prior to her relationship with the reputed father and stated that she "slept with men because I am frigid." Christine presented with an aggressive and hostile air. She stated that she was a 'loner' and neither liked nor trusted people. She had been living with the reputed father for two years. Neither had any intention of marrying the other. If refused therapeutic abortion, she stated that "I will consult a backstreet abortionist, but that is a prolonged suicide so I may as well just commit suicide myself." The consultant psychiatrist's opinion was as follows. "After two interviews with the patient, a discussion with her gynaecologist, who knows her family well, and an interview with her boyfriend, I have decided to recommend termination on psychiatric grounds. The patient has longstanding difficulties in adapting to society and I think that continuing this unwelcomed pregnancy is likely to further prejudice her chances of making an eventually successful adaptation. In this respect, therefore, her psychiatric health would suffer from continuing this pregnancy."

At follow-up the following letter was received from Christine. It is reproduced in full to give a clearer picture of the patient.

"Dear Miss Drower,

According to the various notes which have reached me this week via my brother, I must conclude that you have been going to the most extraordinary ends to trace me merely to help you handle the situation. Hope I can do this by telling you my physical comings and goings over the past two years which is a matter of the wildest conjecture. I would obviously have thought my criticisms and not my physical history would have been of greatest help. However, your empirical categories can no doubt only be based on physical manifestations.

We spent six months of last year at Hout Bay sharing a flat with a bunch of freaks. Hout Bay was lovely but the flat was hellish, however, it still did me some good. While we were there we survived on my leather work and silver and S's theatrical lighting.

Since the beginning of this year just the two of us have been looking after a half completed house in the middle of a vineyard in the wine growing area of Firgrove. Much have I benefited by this though it is still by no means the ideal situation for me as I still have to have some contact with people but at least they are not on top of me.

We are eeking out an existence by doing silver jewelry supplemented by S's lighting.

Apart from that I am needless to say not married and utterly detest children to the very depths of my being and still hope to persuade my gynaecologist to sterilize me once he has got over a quiet laugh about my mental attitudes. I am still apparently difficult to contracept and consequently developed the same problem not long ago, but was lucky to miscarry a few days before I was due to have a backstreet abortion, not being able to face the ordeal with

yourself and Dr. B. once more.

It was just plain bad luck that I did in fact fall pregnant as I have been almost totally frigid since the last episode, for obvious reasons. We are both striving towards celibacy, which for me is an easy matter but not quite so for S.

I think this satisfies all your questions, though possibly you might still like to know that I continue my studies by correspondence, studying whatever interests me, and whatever I think I can benefit from.

Yours faithfully,

Christine"

Like Christine, all but four of the 88 aborted patients considered that a correct decision had been made and all rationalized the event by saying that they felt it had been 'the lesser of two evils'.

69 Patients were traced from the not terminated group. Of these, 38 patients went through to term with six babies being adopted, 18 being born into two-parent families and 14 into one-parent families. Eleven patients reported 'miscarriages', while a further 14 patients gained abortions either legally in South Africa or 'overseas', and six gained successful illegal abortions in South Africa.

Of the six patients who placed their babies for adoption, four were White and two Coloured. Ages ranged from 20 years to 37 years. All were unmarried, although three had had children previously whom they had kept. However, at follow-up all six patients reported feelings of guilt, remorse and anger at having had to have their babies adopted, as well as envy of those women in the nursing homes who were taking their babies home. All found it difficult to accept that adoption might be the most appropriate answer for the babies' future.

The history of Bernadette would probably best illustrate

this aspect of the abortion decision. Bernadette presented at age 19 years, a teaching student and nine weeks pregnant. The gynaecological referral stated that she was self-supporting and putting herself through college. The reputed father was a third year fine arts student and also self-supporting. It was considered that this unwanted pregnancy would mean both sacrificing their careers and jeopardizing their future. As such, the patient was referred for a psychiatric opinion.

On further investigation, Bernadette impressed as a neatly dressed, well-spoken, shy young woman. She felt awkward about her situation but did not appear unduly depressed. She was the eldest of three girls. Her parents had been divorced when she was aged eight years. Her father had subsequently remarried and had four additional children. He did not support Bernadette's family and had taken no interest in her or her sisters since divorcing her mother. Bernadette gave a good history of social, academic and emotional adjustment. The reputed father had been her 'steady' boyfriend since she was aged 16 years but marriage had never been discussed seriously. At the time of presentation she stated that marriage was 'out of the question' as the reputed father's family would not support him, and she herself would not wish him to give up his studies. Bernadette also did not want her own mother to be involved as she felt she had enough responsibilities to cope with in bringing up her younger sisters. She expressed ambivalence about the idea of abortion and stated that if refused she would keep the baby and 'manage somehow'. She expressed a very negative attitude towards the idea of adoption.

The psychiatric consultant's opinion was as follows. "I do feel sorry for this girl, but really do not think that her predicament can be stretched to make a 'psychiatric indication' for termination. She is pregnant by her steady boyfriend of four years standing who is willing (?) to set up home with her and help support the baby. Anyway, she

agrees that she could cope some way or other."

At follow-up the following letter was received from Bernadette in South West Africa, her home.

"Dear Miss Drower,

I am terribly sorry about the late reply as you can see by the address, I am at home at present. The letter you sent recently only arrived here a week ago. Thank you for your consideration and all the letters you wrote. The reason for not replying or seeing you was because I had a lot of problems and had to work.

The first month I worked as a saleslady but they never paid me so I had to look for another job. I got one as a clerk in computer data. My boyfriend mentioned marriage but nothing came of it, he disappeared for a long time so I had to have it adopted. I worked till the second last month and then went into a home. I had a beautiful little boy which had my eyes and his father's mouth and hair. Miss F. of Child Life helped me. We thought of everything to keep it, but having no money or support we decided it would be best for the child to be adopted. I wanted to do nursing and keep it in a creche but the matron said I could only start in January 1976 and could not keep the child there as it was fully booked and trained sisters had the privilege of keeping theirs there first. The nursing home wouldn't accept us either so I had to get a place of my own. I really felt terrible to give him up but was the best thing, I suppose.

My mother found out when she came down to Cape Town for an operation. She really was good about the whole affair, but disappointed. She could not help me to keep it, being divorced she also has my two sisters at boarding school to look after, but I never expected her to help me. I did not even want her to have known.

Anyway I have adapted myself to the situation as best as I can and am working as a telex operator until January.

I then want to do dress designing or drama for which I have applied for a bursary. Either of the two I like, so at least there is an alternative.

The teaching loan I have paid off and I cancelled my bursary just in time.

Being a small town, if you do write back could you please not put the Groote Schuur Psychiatry stamp on the envelope as the gossip mongers have sharp tongues and I want to forget what has happened.

Thank you once again.

Looking forward to hearing from you,

Love, Bernadette"

A number of patients refused termination obtained legal abortions elsewhere. Of the 14 patients who gained such legal abortions, three did so privately prior to the Abortion and Sterilization Act 2/75, three gained abortions in South Africa on other medical indications and eight patients went abroad, six to the United Kingdom and two to Holland. One of the clearest examples of an adverse effect from therapeutic abortion was from this latter group.

Margaret, aged 26 years, was referred at 10 weeks gestation for a psychiatric opinion for therapeutic abortion. She impressed as distressed and agitated at the initial presentation. She was the youngest of three girls from a highly achievement orientated family and had done well at school, university and in her career. She had never received psychiatric treatment herself, but her mother had been treated for schizophrenia since the patient was aged 11 years. Margaret's relationships with her family were poor, characterized by her feeling accepted only when she was academically successful. She had always had a number of girlfriends but had difficulty in making lasting relationships. Prior to meeting the reputed father of the child, she had had two steady relationships with members of the opposite sex. Margaret had been involved with

the reputed father of the child for about a year prior to presentation. He was a 46 year old divorcee with whom she worked. On telling him of the pregnancy he refused to marry her and as she reported, told her to 'get rid of it'. She felt humiliated and hurt by his reaction and stated that she loved him. She expressed very ambivalent feelings about abortion and although she had no specific alternatives, stated that "If I had the baby, I would have to cope. I have coped before with other problems." She also felt detached from the situation stating that, "If I were to believe it, I would fall apart." In view of Margaret's presenting state and ambivalence about therapeutic abortion, she was refused termination.

At follow-up 18 months after the initial presentation, Margaret explained how the reputed father had flown with her to the United Kingdom and organized an abortion for her there 10 days after her refusal for such in South Africa. She stated that she had deliberately allowed herself to be refused a termination - "I really wanted that baby" - and had submitted herself to her boyfriend's wishes in the hope that he might still marry her. Their relationship ended immediately after her abortion. At follow-up Margaret expressed feelings of guilt and confusion about the abortion. She stated that she did not know whether she had done the right thing and had to keep on telling herself that "I did it for the child's sake." She felt that she had needed more counselling before the decision was made and especially afterwards. She said that for four days post-operatively she had cried and had had nightmares about murdering someone since. She stated that she had wanted to become more religious but felt that "God wouldn't want me now." She felt that the experience had made her tougher, stronger and more cynical. In a further communication with the author three weeks after follow-up Margaret wrote, "I was pleased when I thought I would be able to have the baby."

Of the 69 patients traced who had been refused therapeutic

abortion, nine attempted an illegal abortion with six being successful. Illegal abortion is often associated with the desperate attempt of the women to rid herself of an unwanted pregnancy but just as in the procuring of legal terminations, an illegal abortion may actually be engineered by a person other than the woman concerned. Belinda is a case in point.

Belinda, aged 19 years, presented at six weeks pregnant. At presentation she was well controlled and co-operative and did not impress as depressed or distressed. She was an only child and the product of an extramarital union, a fact she did not know. She had a poor relationship with both her parents. She found her father distant and remote and her mother controlling and dominating. She had shown signs of rebelling against the cold atmosphere at home since early adolescence and had been placed in boarding school 'to control me'. At school Belinda struggled academically, failing twice, but no complaints about her conduct were made by the teachers. After leaving school she joined a drug-taking subculture for a number of months before settling down to training as a nurse. During this period she had been seen by a consultant psychiatrist on a few occasions due to conflict with her parents. There was no family history of psychiatric illness. Belinda tended to be shy and reserved with her peers and preferred to have a 'best friend' than to be part of a group. She had had one steady relationship with a member of the opposite sex involving sexual intercourse. Her parents tended to disapprove of her choice of friends. Her pregnancy was the result of a casual relationship with Belinda having no further contact with the reputed father after the conception. When she presented her mother accompanied her. Her mother had "guessed I was pregnant when I got a bit depressed." At the interview Belinda stated that she would like to have the baby, but felt that she should have an abortion for her parents' sake. She was clearly ambivalent about termination of pregnancy.

Belinda's mother was also interviewed. She pressed

for termination and when it became obvious that this would probably be refused, she stated that she would then seek illegal aid even though she recognized the dangers of such action. She expressed a lot of guilt surrounding the birth of Belinda herself.

The consultant psychiatrist stated that, "I do not feel that continuation of this pregnancy is likely to seriously affect the patient's future mental health." Immediate follow-up was arranged, but Belinda's mother could not be dissuaded from seeking illegal aid. One month after initial presentation Belinda was seen again. She related her experience in a controlled and unemotional manner. However, she admitted anger at having allowed herself to have an abortion and had found it traumatic and painful. She related how she was having to pay her parents back financially as a means of punishment. She stated again that she would like to have had the baby but that her mother would never have allowed her to keep it and added, "so I suppose it was for the best."

At follow-up 12 months after initial presentation, Belinda said that she would have liked to have had more counselling before the abortion decision was made. She felt that she would have liked more support in making her decision and said that she had felt rejected by her parents. Guilt and shame had been prominent feelings initially after the illegal abortion, but both had faded with time. Belinda felt that the experience had made her 'softer inside' but harder on the outside, particularly in her attitude towards men. She still stated that she would like to have had the baby but felt that in view of her parents' attitude, perhaps an abortion had been appropriate.

In 32 cases of those patients who went through to term and kept their babies, 18 were born into two-parent families and 14 into one-parent families. Eight of the babies born into two-parent families had parents who were already married, eight had parents who married after refusal for

abortion, and in two cases the parents were married shortly after the birth. The success of such forced marriages is often questionable. In this sample of 10 women, eight reported a successful union with the reputed father and in all the cases, marriage had been discussed as a possible outcome of the relationship prior to the conception. All reported having been accepting of and having enjoyed the pregnancy and were grateful for having been refused abortion. All eight of these women felt that the experience had been positive and growth producing. Two patients reported an unsuccessful union with the reputed father. In both cases the women concerned had consciously wanted to have and keep the baby, while their respective partners felt trapped by their responsibility in the situation. An example of this latter situation is Maureen.

Maureen, aged 29 years, presented at 10 weeks gestation. The referring doctor felt that she was displaying suicidal tendencies and as there did not appear to be any possibility of marriage or a steady relationship, considered that therapeutic abortion might be indicated. She impressed, at initial presentation, as nervous and anxious, and uncertain about what to do. Maureen was the younger of two girls of elderly parents and was concerned about their reaction to the pregnancy. Neither she nor family members had received psychiatric treatment. She had been an average scholar at school and after matriculation had been in steady employment. As regards interpersonal relationships, she described herself as an easy mixer, liking to get out and being with people, although by nature she felt she was basically shy and reserved. She reported having had one steady relationship with the opposite sex lasting five years during her early 20's and since that time, had mixed on a more superficial level until her relationship with the reputed father. She was fond of both her parents but due to their age, felt that she had never really been able to get close to them. The reputed father was a 39 year old divorcee with whom the patient had

been involved for a period of four months. Maureen stated that she desperately wanted to get married, that she wanted children, could not give the baby up for adoption and felt ambivalent about abortion - "It might make me a mental wreck." She said that her boyfriend had been very supportive throughout but made repeated excuses about not marrying her. In a separate interview with the reputed father it emerged that his main concern about marriage was the fact that he had homosexual tendencies. There were no psychiatric grounds for recommending termination, so this was refused. After this decision a number of conjoint interviews were held with Maureen and the reputed father. His sexual problems were discussed and he remained supportive of the patient. Eventually he agreed to marriage, although reluctantly. Maureen at this point was delighted and glad that she had not been terminated.

At follow-up 12 months later, Maureen stated that she definitely considered that it was right that she had not undergone a termination of pregnancy and said that she "shuddered at the thought every time I look at my baby." However, she wished she could have had more counselling with regard to her marriage. Her relationship with her husband had deteriorated to such an extent that at follow-up they were living completely separate lives. Both lived in and worked at the same hotel. They lived in separate quarters. No sexual relationship existed. Maureen was financially supporting the baby with her husband giving occasional gifts. Although initially thrilled at the time of the birth, by follow-up he had withdrawn from the baby and took little notice of her. Maureen had been placed on tranquillizers by her general practitioner due to the relationship with her husband, and at the time of follow-up was seeking legal advice with regard to organizing regular maintenance and possible divorce.

Of the 14 babies born into one-parent families, only one of the mothers had been married previously. The ages of

these women ranged from 16 to 35 years. Four were Coloured and 10 White. All had been nulliparous prior to the birth. At follow-up all expressed positive attitudes towards the baby and viewed the experience in retrospect as having been a positive one. Only three of these patients still kept contact with the reputed father, with two of them still hoping to marry him. A fourth patient had married another man and another had a steady boyfriend. The remainder were involved in purely platonic relationships. Of interest in this group is the fact that all but one patient had received ongoing support from her immediate family. None of these patients had received psychiatric treatment or counselling since refusal and all felt that they had, and still were coping with the situation well.

Two points may be illustrated by case histories of patients falling within this group. Firstly, that of the woman who deliberately falls pregnant, not so much as to corner a man into marriage, but because she specifically wants to have a child. Secondly, the problem of the parenting of illegitimate babies born to adolescent females and the possible future effect of this on the child.

Hillary is an example of the first group. She presented at age 34 years at nine weeks gestation. At initial presentation she impressed as open, warm, co-operative and realistic about her situation. She showed no signs of depression but rather needed reassurance as to whether or not to go through with the pregnancy. She had been referred by her gynaecologist as he felt that she was possibly being unrealistic about her wish to continue with the pregnancy. Four months prior to presentation she had undergone an operation for removal of a cancerous growth in the uterus and had been told that a hysterectomy would be necessary should this recur. Hillary was one of three siblings. She had been a very hyperactive child and had been seen at a child guidance clinic while at primary school. She had received no further psychiatric treatment. Her academic record at school and

university had been above average and at the time of presentation she held a senior position in her field of employment. She related well to her peers and had a number of close friends. Hillary had also had a number of relationships with the opposite sex but stated that although she would like to get married and have children, she felt she was basically too fussy in her choice of men. She stated that she felt she had a good relationship with both her parents. Hillary had been involved with the reputed father of her child for a year prior to conception. He was seven years her junior and she tended to 'mother' him. She stated that after she had had the threat of a hysterectomy put to her, she deliberately took no contraceptive measures so as to fall pregnant. She saw this as possibly her last chance of having children of her own. Her initial reaction to learning about her pregnancy was that of being thrilled as was that of her boyfriend, who offered to marry her. She refused this offer, feeling that the relationship was not strong enough to withstand the stress of marriage. Hillary did not request an abortion but wanted reassurance that she could cope and was not being selfish or idealistic about the situation. However, the fact that she had already made arrangements about her work and placement of the baby at a creche, did to a certain extent show that she was facing the realistic demands of having to care for a baby.

The opinion of the consultant psychiatrist in this case read as follows. "There is no indication for termination of pregnancy in this case. There is no evidence of her being a significantly disturbed personality and her present emotional state is not one that gives rise for concern. She has a great need to reinforce her insecure femininity and she sees having a child as an opportunity to do so. I believe that she will cope with the situation."

At follow-up 12 months after initial presentation, Hillary stated that she felt the correct decision had been made as regards therapeutic abortion but that "one always

feels conflicting feelings." She felt that she had coped well with the situation and did not need further counselling after the decision had been made. She stated that she had felt maternal about and accepting of the pregnancy but at times had felt guilty that the baby would not have a legal father, and at times anxious about the responsibility she had taken upon herself. Hillary was still involved with the reputed father who had been present at the birth and with whom she had been living for the past six months. She summed up her present feelings as great joy and happiness associated with her baby, but tremendous guilt associated with the reputed father. At follow-up she had decided that she wanted to break off their relationship. He had begun to drink heavily and was beginning to become jealous of the baby. She found herself having to 'mother' him too and felt that now she had her own baby, she had found a healthier outlet for her maternal needs. She felt she had deliberately used him by falling pregnant consciously without telling him and now that she did not need him, she no longer wanted to associate with him. At the same time, she did not wish to deprive her baby of its father.

Hannelie, aged 16 years, is an example of the second group that illustrates the difficulty of an adolescent parenting an illegitimate baby in her own family. Hannelie presented at 15 weeks gestation. The referring gynaecologist did not consider that there were psychiatric indications for therapeutic abortion but referred the patient due to her mother's hysterical reaction to the pregnancy. Hannelie presented as well developed for her 16 years, a combination of both maturity and naiveté about her situation, but showed no overt signs of depression or distress about the situation. Her mother was an elderly, dominating woman feeling very distraught about the pregnancy and demanding that it should be therapeutically terminated. Hannelie was the youngest by 10 years of three siblings. Her parents were both in their early 60's. She had no psychiatric history, although

her elder sister had been treated on an outpatient basis for anxiety. At the time of presentation Hannelie was repeating Std. VIII. In high school, teachers had complained that she did not work hard enough and the previous year she had been truanting, caused according to her mother, by an association with a previous boyfriend. She had displayed no other rebellious behaviour although her mother stated that she had found her difficult to 'handle' since her association with the reputed father. She described Hannelie in a very negative way. The patient had always been an easy mixer with members of both sexes. She stated that she had been involved with her 19 year old boyfriend for eight months and had had a regular sexual relationship with him for six months using no means of contraception, although "I knew I was likely to fall pregnant but I didn't bother to worry about it." Hannelie was adamant that she did not want an abortion, even though her parents would not consent to her marriage, which was the wish of both herself and her boyfriend. The psychiatric consultant was of the opinion that even though the patient did not want a termination, and it was her mother who was pushing for it, she would not have had sufficient grounds for therapeutic abortion even if she herself had requested it. Hannelie was seen on a number of occasions after the refusal for abortion. Her parents maintained their adamant stand about not allowing her to marry and continued to disapprove of her seeing the reputed father. However, they began to show more support for the patient and insisted that she remain at home during the pregnancy and did not push the issue of adoption.

At follow-up a year later, Hannalie remained adamant that it was the correct decision not to terminate and that she had not wanted an abortion but that it had been her mother who was pushing for it. She felt that she had had enough counselling throughout. She was still living with her parents, had left school and was working as a clerk. She stated that she had been very accepting of the pregnancy

but that she had been upset by the continued conflict between her parents and the reputed father. She had maintained her contact with him and still wished to marry him. Since the birth of her baby, her mother had taken over its welfare and according to Hannelie, tried to undermine her role as its mother. She organized its day to day needs and would refer to Hannelie as the baby's 'auntie'. Her mother would also refuse to allow the reputed father into the house to see the baby, but at the same time expected him to pay maintenance. Hannelie was very resentful of the situation, which she did not know how to handle. She saw herself as being overridden and pushed into the background.

One of the major concerns of those involved in the assessment of patients for therapeutic abortion is the handling of those patients who threaten suicide. Whether such a gesture is a genuine sign of distress and depression or whether it is being used as a manipulative measure must be established in each individual case. In the group of 90 patients who were refused therapeutic abortion, 14 patients had threatened suicide if met with such refusal. At follow-up 69 of the refused termination group were traced; of these three had made suicide attempts with one having threatened such action at initial presentation. Two of these patients were single and one divorced. Two were Coloured and one White, with their ages being 26, 25 and 16 years. All three are best illustrated by giving brief case histories.

Marwa was a 26 year old Moslem divorcee and mother of one child, who was receiving ongoing psychiatric treatment at the time of her discovery of her pregnancy. She had a full-scale IQ of 82 on the Wechsler Adult Intelligence Scale (National Institute for Personnel Research. Undated). Her diagnosis was that of anxiety in an inadequate personality. She had lived with her family since her divorce four years prior to presentation. She complained of various somatic symptoms and had numerous social problems relating to her financial situation and interpersonal relationships with her

family. The reputed father was a man Marwa had associated with for three months and with whom she had broken off contact prior to the discovery of the pregnancy. Her main fear surrounding the pregnancy was the reaction of family members as she came from an orthodox Moslem family. She stated that if she had accommodation of her own she would go through to term. The patient made no threats of suicide. The opinion of the consultant psychiatrist was that there were no adequate psychiatric grounds for therapeutic abortion although there were social indications, and as such abortion was refused. Three follow-up appointments were made for Marwa, all of which she failed to attend.

At follow-up a year later, Marwa related how she had met the reputed father shortly after having been refused therapeutic termination of pregnancy. She said she was angry and distressed and in this state attempted suicide by taking an overdose of purgatives. Shortly after this she 'miscarried'. She stated that she felt it was correct that she had been refused therapeutic abortion and said that she had not attended her follow-up appointments as she was embarrassed about having taken an overdose.

Valerie is the second of these cases. A Coloured female aged 25 years, she presented at 22 weeks gestation. She was living with her mother and younger brother and was the sole support of both. Her mother accompanied her to her initial presentation and impressed as a very dependent, demanding, whining woman who leaned very heavily on the patient both for emotional and financial support. Valerie related an incident of unreported rape through which she claimed to have fallen pregnant. She was upset and weepy and threatened suicide if refused therapeutic abortion, but her mother appeared to be placing additional stress on her through her hysterical reaction to the pregnancy. Valerie's main concern was the fact that she was the sole supporter of her mother and brother and did not see how she could cope with a pregnancy on top of this responsibility. The consultant

psychiatrist felt that Valerie had strong socio-economic grounds for termination but did not feel that she qualified on psychiatric indications in terms of the South African law. Valerie was seen on two occasions after her refusal and appeared to have accepted the situation and was making arrangements for her confinement, although she did not know whether she would place her baby for adoption. She also stated that her mother was gradually coming to terms with the situation. She then failed to attend a further two follow-up appointments.

At follow-up 12 months later, Valerie admitted to having attempted suicide one week after refusal by taking an overdose of Codis. She stated that she didn't really attempt suicide, but had felt very desperate at the time. She related how she had gone through to term with the pregnancy and had placed her baby with her elder brother up country, but said that her mother did not know that she had kept him. She had spent the last few weeks of confinement in a home for unmarried mothers. She felt that the correct decision had been made in refusing her an abortion and was happy that she had kept her baby. She saw her means of escape from her mother as being for her to go up country herself to work and look after her baby, and planned to do this.

The third case is that of Theresa, a 16 year old White girl who presented at 12 weeks of pregnancy. She was the youngest of three children and was a Std. IX pupil. At the time of presentation she was receiving ongoing psychiatric treatment, her diagnosis being that of adolescent turmoil. Her entry into treatment eight months prior to presentation had been precipitated by a suicide attempt. She gave a history of poor social adjustment and unsatisfactory interpersonal relationships. Her relationship with her parents was characterized by fear of her father who was rigid, strict and demanding of her, and by contempt for her mother whom she felt was 'under father's thumb'. Theresa described herself as being a very moody person with frequent temper

outbursts and 'generally making myself disgusting'. Her boyfriend was a 21 year old student with whom she had been involved for six months. She was openly ambivalent about the pregnancy and abortion, her main fear being associated with her father's reaction to the situation. Both parents were very upset by the news and attempted to push for termination. However, in respect of Theresa's ambivalence, a decision not to terminate was made.

At follow-up 14 months after initial presentation, Theresa stated that it was correct for her to have gone through to term. She related how she had married the reputed father after abortion had not been granted and spoke of her turbulent marriage since. She felt that they were both far too young to have taken on the responsibility of parenthood and marriage. She had separated from her husband one month prior to follow-up and at that time had made a suicide attempt by slashing her wrists. She had continued to receive psychiatric treatment.

At follow-up it was found that a total of 12 of those patients traced in the termination group and six of those in the not termination group had had, or were still receiving psychiatric treatment. The fact that 2/3rds of those patients who were receiving treatment had had their pregnancy terminated, supports the fact that some of those granted therapeutic abortion are considered to be so significantly psychiatrically disturbed as to need long-term care. However, it could be argued that the need for psychiatric treatment might be the outcome of an adverse reaction to an abortion. Examination of the records revealed that three of these 12 patients had received psychiatric treatment prior to initial presentation, the diagnoses being one psychotic and two personality disorders. The remaining patients were all referred for psychiatric treatment as a result of the findings on termination assessment, which included depression, adolescent turmoil, personality disorder and mental retardation. Of the six patients who had had psychiatric treatment

since initial assessment but who had not been terminated, four had received such treatment previously for personality disorder. The remaining two patients were in therapy for adolescent turmoil.

A greater increase in the use of alcohol, tobacco, dagga and tranquillizers was found among those terminated at follow-up comparing them with those not terminated. However, again this may be related to the fact that those granted termination are considered to be psychiatrically disturbed.

Considering the quality of mental health at follow-up, it was found that 13 patients of those terminated as opposed to seven patients not terminated reported an adverse personality change, while six in the former as opposed to one in the latter reported greater social isolation.

An adverse personality change was linked to the patient's feelings about and reactions to the abortion decision. In the termination group five of these patients were White and eight Coloured, 10 were single and three married and the mean age was 23,8 years with a range of 12 years to 33 years. Three of these patients had already been referred for psychiatric treatment at the time of the abortion assessment. An overriding sense of guilt about the abortion and unsuccessful attempts to reintegrate themselves into their social environment were the main features of adverse personality change in these patients. Such comments as 'it was a sin' and 'the wrong decision was made' came from this group. One patient at follow-up wept throughout and blamed the state of her subsequent marriage to someone else on the abortion. Another patient stated that she had previously been very fond of children, but since her own termination had become increasingly irritated by them. She was distressed and bitter that her friends were allowed to have children and not herself, but could not have seen herself coping any other way. A further patient reported feeling regret and a 'dull ache' every time she thought about the abortion. She felt she had been trapped into having an abortion by refusing to

accept any other alternatives and considered that she had 'made a mess of my life'. A letter was sent to a further patient who lived out of town who wrote her reply as follows on a religious card: "I cannot talk personally about myself let alone writing about myself. If I have courage, I'll write to you."

Seven patients who were among the group refused termination reported an adverse personality change related to the steps they had taken after the refusal for abortion. Two of these patients were bitter at the fact that they had found it necessary to have their babies placed for adoption. Four patients had gained abortions elsewhere, one overseas, one legally in South Africa prior to the passing of the Abortion and Sterilization Act 2/75, one on medical grounds and one illegally. All had been very ambivalent about abortion at the time of initial presentation and at follow-up felt that they should have gone through to term. A seventh patient had kept her baby and although she was glad she had done so, admitted that she had ruined her child's life. Six of these patients were unmarried and one divorced, six were White and one Coloured, and the mean age was 24,7 years with a range of 19 years to 33 years. One of these patients had received previous psychiatric treatment and none had been referred for ongoing psychiatric treatment.

The yardsticks used to assess adverse personality change were the experience of the patient and an altered attitude to future interpersonal relationships, especially men. Several patients from both groups reported feeling more wary of men and preferring to maintain platonic rather than sexual relationships with men.

Greater social isolation was admitted by six patients in the termination group as opposed to one in the not termination group, and ranged from one week to six months after the abortion decision. In those terminated, an overlap of half was found between those reporting adverse personality change and greater social isolation. In each case it would

appear that the patient had overriding guilt feelings about the termination and dreaded others discovering the fact. None had been able to accept the situation but all felt that there had been no other appropriate alternative.

One of the concerns expressed in assessing patients for therapeutic abortion is the availability of support in the community for the individual patient, particularly for the girl who is refused a therapeutic abortion. At follow-up there was found to be a statistical difference in the amount of parental support given by parents to those in the termination and not termination groups in favour of the latter. In addition, more siblings in the latter group knew of the pregnancy, not surprisingly since a pregnancy is more difficult to conceal than an abortion. It is open to speculation as to whether or not knowledge of supportive parents weighted the decision not to terminate the pregnancy.

What of the reputed father? In just over half of the patients in both groups the reputed father proved to be a supportive figure and accepting of the pregnancy.

With regard to support from the patient's peer group, a large number of those patients terminated reported a lack of such support. However, altogether only 21 patients reported having been left alone to cope with the abortion or pregnancy, with 12 of these falling within the termination group.

In inquiring about the attitude change towards therapeutic abortion at follow-up, these were largely unchanged, with only 13 patients, seven from the not termination group and six from the termination group altering in favour of therapeutic abortion.

Another area of interest at follow-up of therapeutic abortion patients is their use of contraception since initial presentation. A large proportion of patients in both groups admitted to using some form of contraception since the birth or termination.

In exploring patterns of heterosexual relationships since

the abortion decision, it was found that just over half of the patients traced were no longer involved with the same man as before. However, of those patients who had maintained their relationship, it was found that more patients who had had termination were either engaged or married to the reputed father. Only 11 of the 70 patients no longer involved with the reputed father were either engaged or married to someone else. It is of note that no statistical difference between the termination and not termination groups was found in relation to those variables concerned with the patient's relationship with members of the opposite sex since initial assessment.

Twenty-two patients reported changes in peer association. Many of these also reported greater social isolation since the abortion decision. Just over one-third of the total sample reported being withdrawn, antisocial and isolated initially. In the same way as the depressive reaction to the abortion decision, this phenomenon appeared to recede over time.

There was a statistically significant difference between the two groups with regard to whether or not the consultant psychiatrist had made the correct decision. In the modified sample of 135 patients, 70% agreed with the decision, 65% of these having been recommended and only 35% not recommended for therapeutic abortion. Thus, the statistical difference may be accounted for by the greater number from the not termination group who reported disagreement with the decision.

Hypothesis number four postulated that "if therapeutic abortion is refused on psychiatric indications, then all patients will experience negative feelings to the continued pregnancy." At follow-up it was found that of the 69 patients on whom information was available out of the total of 90 refused therapeutic abortion on psychiatric grounds, a total of 38 went through to term. Of these 38 patients a total of four felt negative about the continued pregnancy, 17 were positive and 17 patients were ambivalent. Since the predominant attitude towards the continued pregnancy

was a positive one, the hypothesis was refuted.

Hypothesis number five postulated that, "in the absence of psychiatric grounds for the termination of an unwanted pregnancy, little serious damage to the mental health of the patient ensues if termination is refused, as long as counselling and psychiatric services are available." The results of the mental health outcome at 12 to 18 months after initial presentation are given in Table 95, Chapter 10. In those not terminated, compared with the other group, there were fewer patients in psychiatric therapy, fewer reported an increase in the use of alcohol, tobacco, dagga and tranquillizers, and fewer reported adverse personality change or greater social isolation. Each patient whether terminated or not, was offered counselling and in some cases psychiatric treatment after the decision had been made. From the results gained in this study, it may be concluded that hypotheses number five was supported.

B. DISCUSSION OF THE RESULTS OF THE PRESENT STUDY IN RELATION TO PREVIOUS STUDIES

It is very difficult to compare data of any two studies of women presenting for assessment for therapeutic abortion due to the uniqueness of each population sample, the context in which the abortion decision is being made and the prevailing laws. The latter will determine which women are referred to a special psychiatric clinic as described in the present study. Although under the Abortion and Sterilization Act 2/75, all women seeking therapeutic abortion must be assessed at state or provincial hospitals, due to the restrictive grounds for legal abortion only those thought to have clear-cut indications are referred.

The present study reflects the general trend of the referrals being mainly the unmarried (72%) and the peak age group being that between 21 to 30 years (45%), with 37% under the age of 21 years. Smith (1973) in the United States observed in her study of 154 women presenting with an unwanted pregnancy, that 42% of her sample were under the age

of 21 years and 50% between the ages of 21 and 30 years. 19% had had previous psychiatric contact as against 16% in the present study. She also found that 76% of the women presented prior to the 12th week of gestation as compared to 59% in this study. The latter discrepancy may be accounted for by the fact that in Smith's study only 7% of her sample came from the lowest social-economic class V and VI by comparison with 23% in this study. Since for 13 of the 16 month sample period presented here, women were not legally obliged to seek assessment at state or provincial hospitals, many of those able to afford private treatment probably did so.

With respect to parity, Steinhoff (in Osofsky and Osofsky, 1973, p.222) states that "women who have never had a child constitute a large and important segment of the abortion population." In the present study this accounted for 70% of the total. Steinhoff found that unmarried women under the age of 25 years used abortion to delay the onset of child-bearing because they were not yet ready or able to marry and raise a family. Women who had had previous children sought an abortion because they regarded their present family as complete. 19% of the women of the present study had between one and three children, while 11% had 4 or more children, and the remaining 70% were nulliparous.

Writers on the subject of therapeutic abortion have proposed a variety of opinions as to the effect of this procedure. Simon and Senturia (1966, p.387) in their review on the literature on the psychiatric sequelae of abortion comment as follows: "The findings and conclusions range from the suggestion that psychiatric illness almost always is the outcome of therapeutic abortion to its virtual absence as a post-abortion complication." As noted in Chapter 4, over the last decade there has been a change in the recorded incidence of psychiatric sequelae of therapeutic abortion. Recent studies indicate that despite a negative reaction to the whole experience, it does not result in psychiatric illness or longlasting regret (Friedman et al, 1974).

In the present study, most women admitted at follow-up that they felt less depressed than they remembered being at initial assessment. In addition, those recommended for therapeutic abortion expressed greater relief and happiness than those refused a termination. These, in turn, felt more guilt and anxiety.

Peck and Marcus (1966) in the United States followed up 50 women, half of whom were recommended for termination on psychiatric grounds and half on other medical indications between three and six months after therapeutic abortion. They found that of all the women, only one was considered worse after the abortion. Mild and brief depression was reported by 20% of the subjects, but this had disappeared by the time of the follow-up. 36% of the non-psychiatric group had mild, brief depressive reactions accompanied by feelings of guilt about the abortion. In the psychiatric group, 12% reported mild guilt, 12% moderate guilt and 4% severe guilt, while in the non-psychiatric group 28% reported mild guilt, 8% moderate guilt and no one reported severe guilt. At the follow-up interview, 68% of the psychiatric subjects were considered to have an improved psychiatric status, while 20% of the non-psychiatric group were also found to have shown similar improvement. From these findings the authors conclude that "becoming pregnant is not only a precipitating factor in the depressions and anxieties found in the pre-abortion examination, but it is actually the major cause of these reactions, since they are so greatly relieved by terminating the pregnancy" (1966, p.424).

Whittington (1970) in the United States followed up 31 women who had had an abortion on psychiatric grounds. In response to a query about their state of happinesss, 45% indicated that they had been very happy since the abortion, 42% said they were fairly happy, 6% reported fluctuations in mood, 3% said they were mostly 'down' and 3% reported unhappiness. Further enquiry elicited that 68% felt in better mental health, 10% considered that they could be in

better mental health, and 3% maintained that their mental health had deteriorated. To quote Whittington (1970, p.1228), "The data we have suggest that the procedure is not a major psychological trauma, but the information is far from conclusive."

Greenglass (1975) in Canada followed up 188 women nine months after legal abortion and matched these with controls who had not had abortions. He found that regrets about continuing the pregnancy were more common among those who had gone through to term than those who had aborted. He concluded that, "the mental health of a woman faced with an unwanted pregnancy stands a greater chance of improving when the woman has an abortion than when she is forced to deliver a child" (1975, p.756).

Greer et al (1976) in England conducted a follow-up study of 360 women at three months and between 15 months and two years after therapeutic abortion had been performed. 91% of the original sample were interviewed at the initial follow-up and 60% at long-term follow-up. Findings revealed that the percentage of women requiring psychiatric treatment fell from 29% before termination to 19% after termination. Comparison between the existence and severity of depression before the abortion and three months later, showed a significant improvement at follow-up. Guilt about the abortion was rated considerable, moderate, minimal or none, with 37% reporting considerable or moderate guilt before the abortion, but at three months follow-up this had dropped to 13%, and at 18 months this fell to only 7%. Nine patients at three months follow-up and eight at 18 months admitted regretting the termination.

Payne et al (1976) in the United States studied 102 women six months after legal abortion had been obtained to assess the extent of anxiety, depression, anger, guilt and shame and found each to be significantly lower after the pre-abortion period.

The present study shows similar findings to those discussed

above with regard to the lessening of depression and guilt over time, and also those women forced to continue with a pregnancy are going to have more negative feelings about the experience than those who are aborted.

The mental health outcome at 12 to 18 months as reported in the present study (see Table 95) showed that 14% (12 women) of the termination group were receiving or had received psychiatric treatment since the initial assessment. All of those in the termination group had either been in treatment prior to the pregnancy or were referred for such treatment as a result of the interview, while 2/3rds of those in the not termination group had been in treatment previously. In the total sample, 16% of the women had received previous psychiatric treatment. The higher percentage of adverse personality change (15% in the termination group compared with 10% in the non-termination group) and the reported greater social isolation (7% in the termination group as against 1% in the non-termination group) may be accounted for by the fact that those granted therapeutic abortion on psychiatric grounds are considered to be psychiatrically disturbed at the time of assessment and it is arguable whether these changes are a result of the abortion itself.

Smith (1973) reported in her follow-up study of 154 women, 80 of whom were traced, that 5 had sought psychiatric treatment after the abortion as the result of the experience. She also found that although 18% of the follow-up group had been given a psychiatric diagnosis on the basis of the original assessment interview, only two of these had found it necessary to consult psychiatric help.

Greer et al (1976) in England reported that out of a follow-up sample of 326 women, 42 of whom had received psychiatric treatment after the termination, only four women felt that their symptoms were related to the abortion, 25 said that their symptoms were not related and 13 were not sure.

Of particular importance in a study of women presenting for assessment for therapeutic abortion, is the outcome of the

pregnancy of those women denied abortion. In the present study, 69 women of those refused an abortion were traced, and revealed that only 55% went through to term with 46% of the total of 69 women keeping their babies. The remainder of this group either reported spontaneous legal abortion elsewhere or illegal abortion.

Pare and Raven (1970) in England followed up 120 women who had been refused abortion and found that 61% of the women continued the pregnancy with 49% of the total 120 keeping their babies. 36% of their sample reported either a legal abortion elsewhere, illegal abortion or spontaneous abortion. In the present study this accounted for 45% of the non-termination follow-up group.

Meyerowitz et al (1971) in the United States reported that 38% of a total of 60 women refused abortion went through to term. Of the remainder 35% reported an abortion elsewhere and 7% a spontaneous abortion.

Both of these studies reflect similar results to the present study.

CHAPTER 12

CONCLUSIONS

1. This study was undertaken in part, to attempt to throw some light on the factors that appear to influence decisions made by psychiatrists who assess patients for termination of pregnancy. In the discriminant analysis that examined all the variables, derived from the assessment interviews, the variable 'referral for psychiatric treatment' weighted the probability that the patient would be in the termination group. Examining the information from the 107 patients in this group, 17 were referred, some on the basis of distress complicating previously known psychiatric disorder, others on the basis of the mental state findings at the time of interview. All the variables that could be individually considered as 'psychiatric', were fairly evenly distributed in the two groups and did not seem to have weighted the decision either way. Of course, considered as a cluster, these probably contributed to a person being considered, or having been in the past diagnosed, as psychiatrically disordered. However, taking those with undisputed, documented and previously treated psychiatric illness, there was no evidence that these were favourably considered for termination and in fact, most were not recommended for termination. Some of the mentally retarded were favourably considered but apart from these, the data that weights a decision for termination on psychiatric grounds remains undefinable.

2. The 'non-psychiatric' or psychosocial variables of age, parity and previous sexual partner(s) were found to be significantly different between the group recommended for termination and the group not recommended for termination. Age weighed in favour of termination for those under the age of 16 years and over the age of 30 years, a predictable finding since in the initial stages of the study, the Abortion and Sterilization Bill of 1973, which covered pregnant girls under the age of 16 years, was used as a guideline. The

significance of parity hints at the possibility that the long-term adverse effects on the mental health of a multiparous mother rearing an unwanted child could have been taken into account. In the discriminant analysis, evidence of more than one intimate relationship, which weighted against termination, emerged as one of the three main factors which appeared to influence group allocation and reflect decision making. Perhaps this was regarded as indicative of a personality disorder, which of itself was insufficient grounds for termination. It may be concluded that in the reported study, 'non-psychiatric' or psychosocial data appeared to influence the recommendation made in the abortion decision.

3. The woman's attitude towards the pregnancy and/or abortion seemed to favour the decision not to terminate. This applied specifically to ambivalence about the pregnancy and/or abortion; other feelings such as anger, guilt and hurt however, were evenly distributed in both groups.

4. Consistent decision making about abortion was found in the reported study throughout the period 1/2/74 - 31/5/75. Data from women early in the study, i.e. 1/3/74 - 31/5/74, was compared with another group a year later over a similar three month period. Minor differences in the psychosocial data were found in the two groups. The fact that none of the three major variables isolated in the discriminant analysis as factors in group allocation were significantly different in the two samples, suggested that a reasonably consistent policy was maintained throughout the period of the presented study.

5. At follow-up 12 - 18 months after presentation, significant differences in the depth of depression between the initial reaction as given retrospectively and that reported at follow-up occurred in those terminated as well as those refused termination. Thus, depression occurring in women either recommended or refused abortion, as a rule recedes over time. Relief was reported by members of both groups initially and later, but those refused abortion felt greater regret about the decision

both early and later. At long-term follow-up, little depression, guilt or anxiety was admitted by members in either group. There were no serious psychiatric sequelae in either group.

6. The reported study also shows that women refused therapeutic termination of pregnancy seek and obtain abortions by other means. This is borne out by the finding that of the 69 women followed up who had been refused abortion, only 38 went through pregnancy to term.

7. Threats of suicide were made at the initial assessment by 14 of the 90 women refused termination. At follow-up it was found that three of the women in this group had actually made suicide attempts, only one of these having threatened such action at initial presentation. Suicide, therefore, should not be overlooked as a risk in women refused an abortion, whether they have threatened it or not.

8. At follow-up, of the 38 women who went through to term, four expressed negative attitudes towards the continued pregnancy, 17 felt positive and 17 were ambivalent. Thus, in the sample presented here, of those who went through to term, predominantly positive attitudes were expressed towards the continued pregnancy.

9. With regard to the mental health outcome at 12 - 18 months after initial assessment, little serious damage to the mental health of those not terminated was found. Mild emotional distress was experienced by those terminated during the period following the procedure. However, this is not surprising since by definition, they were considered more psychiatrically unstable. In most women, this was not severe enough for them to seek psychiatric help, although they admitted using more alcohol, tranquillizers and cigarettes.

10. The findings in this study confirm the findings of many other authors, i.e. that it is virtually impossible to set

out guidelines for psychiatrists to use in making decisions about terminations, particularly if they are to depend on undisputed psychiatric data, and it would appear as though many social factors consciously or unconsciously enter into professional decision making.

IMPLICATIONS FOR FUTURE RESEARCH

The present study aimed to examine a specific population consisting of all women presenting for assessment for therapeutic abortion on psychiatric grounds at Groote Schuur Hospital, Cape Town, over a 15 month period. As such, the results cannot necessarily be extrapolated to the general population. Since the start of this study, there have been amendments to the Abortion and Sterilization law in South Africa and were this study to be undertaken again, even in the same department, different results might be obtained. Thus, this study can be seen as the attempts of one department of psychiatry to interpret and implement the prevailing law. However, although no comparable study has been undertaken in this country, the results presented here show striking similarities with like situations reported from abroad.

Numerous studies on the reasons for an unwanted pregnancy, the sequelae of abortion or refused abortion and alternatives to abortion have been conducted, particularly in Scandinavia, the United States and the United Kingdom. This study did not attempt to cover all these other aspects. Future studies in the field could well examine specific areas, e.g. different cultural, religious and ethnic aspects of therapeutic abortion within the framework of South Africa's unique and diverse population groups.

Due to the doubtful validity of the results obtained from information given by women at follow-up about their initial reaction to the decision made at the initial assessment, a further study exploring emotional reactions immediately after the decision and then over a period of time would be of interest, recognising how difficult it is to obtain follow-up data from women, many of whom wish to forget the whole affair. However, a further follow-up of the two groups presented here might be feasible to assess long-term reactions to the decision, and to assess how

lasting the feelings of relief in the termination group and regret in the non-termination group may be. It is doubtful if a follow-up rate of 80% would be obtained again.

Of importance is the outcome of children born to women refused therapeutic abortion. In this study it was shown that four of the 38 women who went through to term expressed consistently negative attitudes towards the continued pregnancy and some seemed ambivalent about the child up to term. Long-term follow-up of these women, their attitudes towards the children born and the long-term effect of these attitudes on the mental health of their offspring, could be undertaken to support or refute the findings of Forssman and Thuwe (1966) that these women have difficulty in mothering.

Little attention has been given to the role and reactions of the reputed father of unwanted pregnancies.

Finally, no attempt has been made in South Africa to assess how psychiatrists feel about their role in interpreting and implementing an abortion law that assumes an almost superhuman capacity to predict the future.

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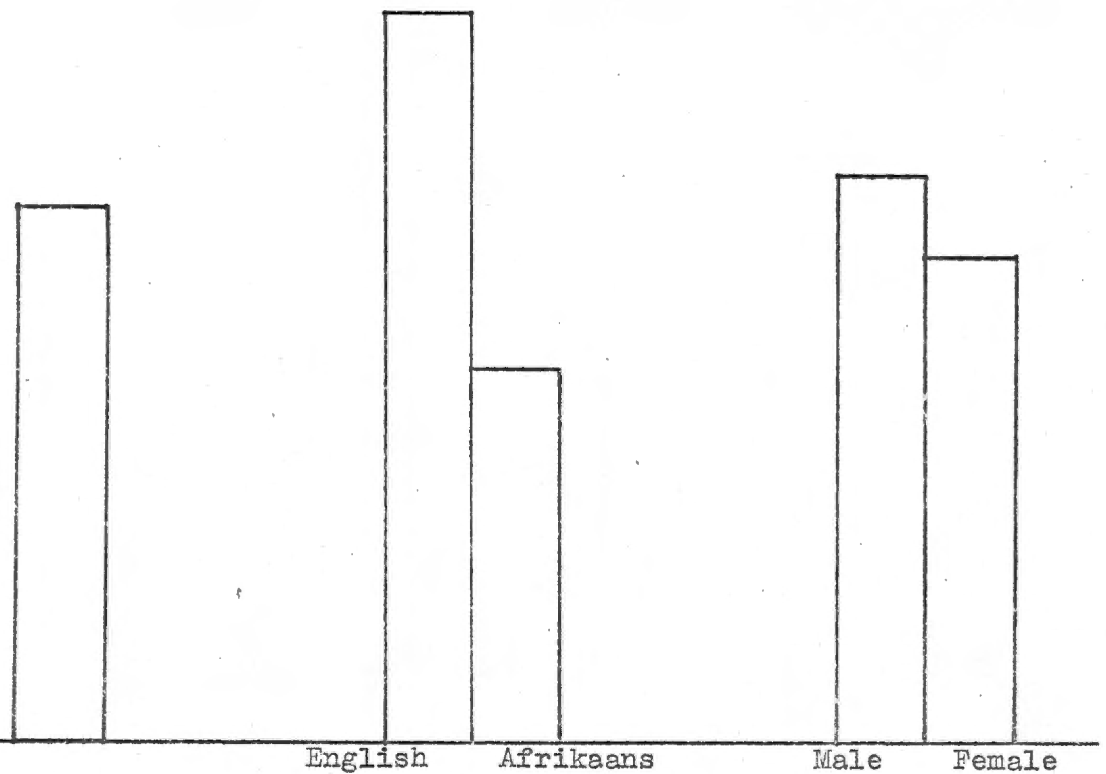
APPENDIX A

PUBLIC OPINION AND ABORTION IN SOUTH AFRICA

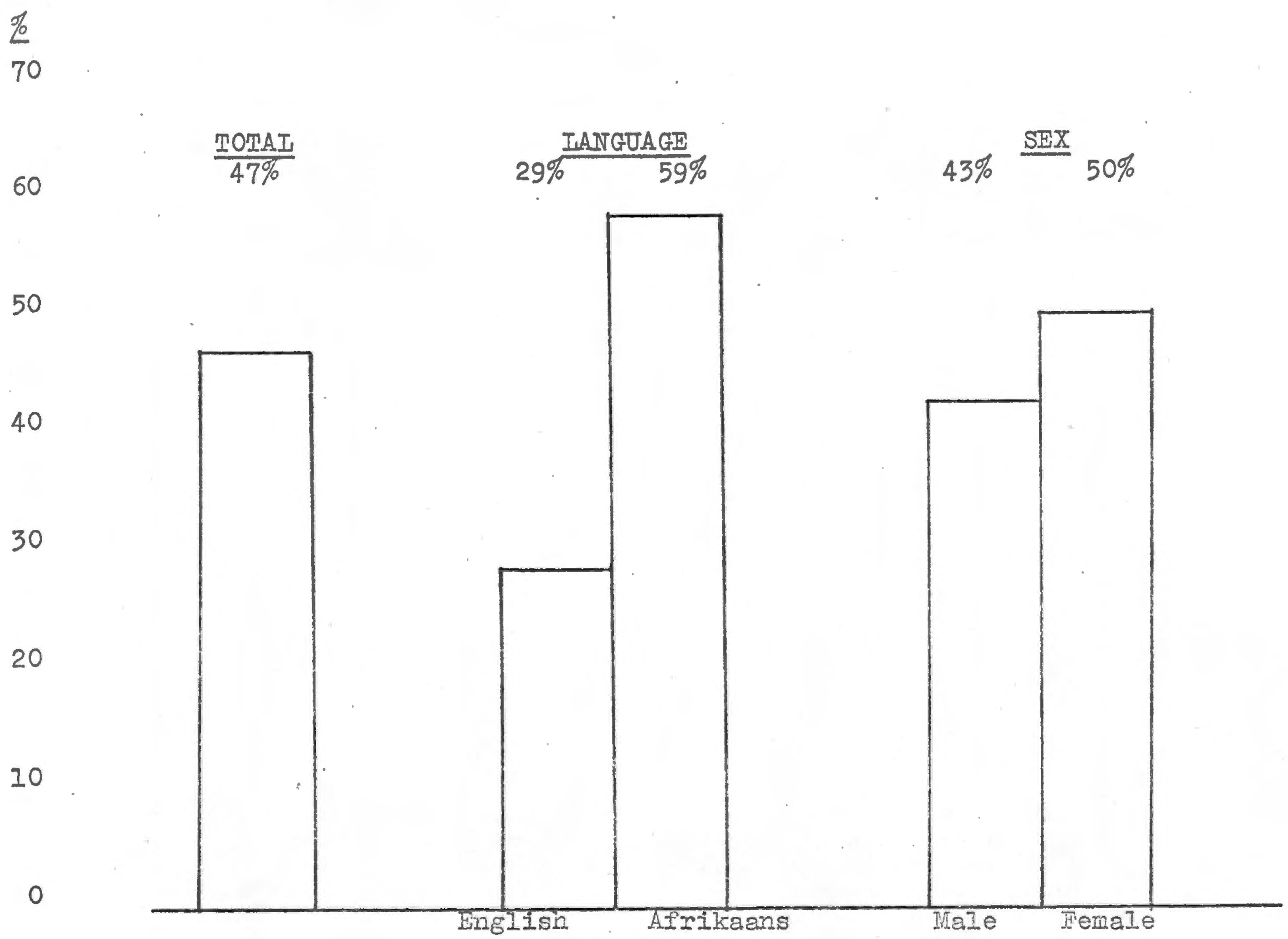
QUESTION: Do you agree or disagree that it should be made easier to obtain a legal abortion in South Africa?

ANSWER: Agree.



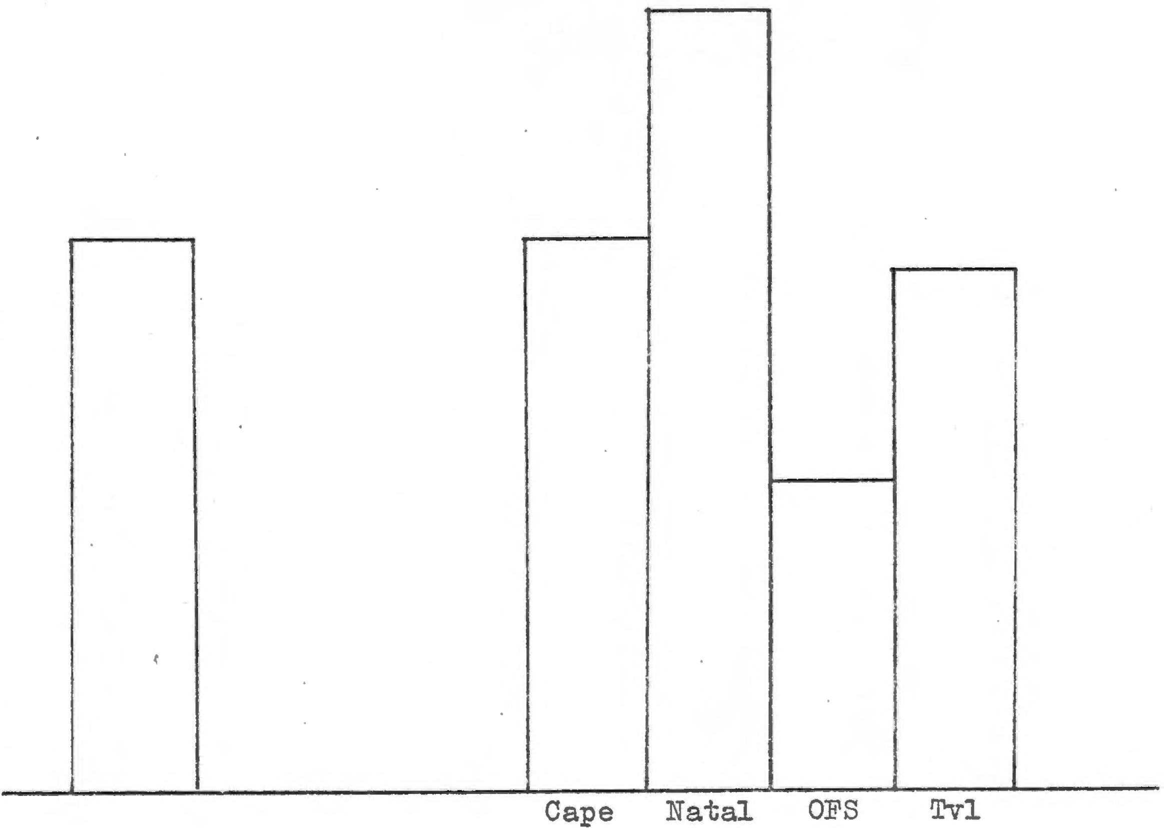
QUESTION: Do you agree or disagree that it should be made easier to obtain a legal abortion in South Africa?

ANSWER: Disagree.



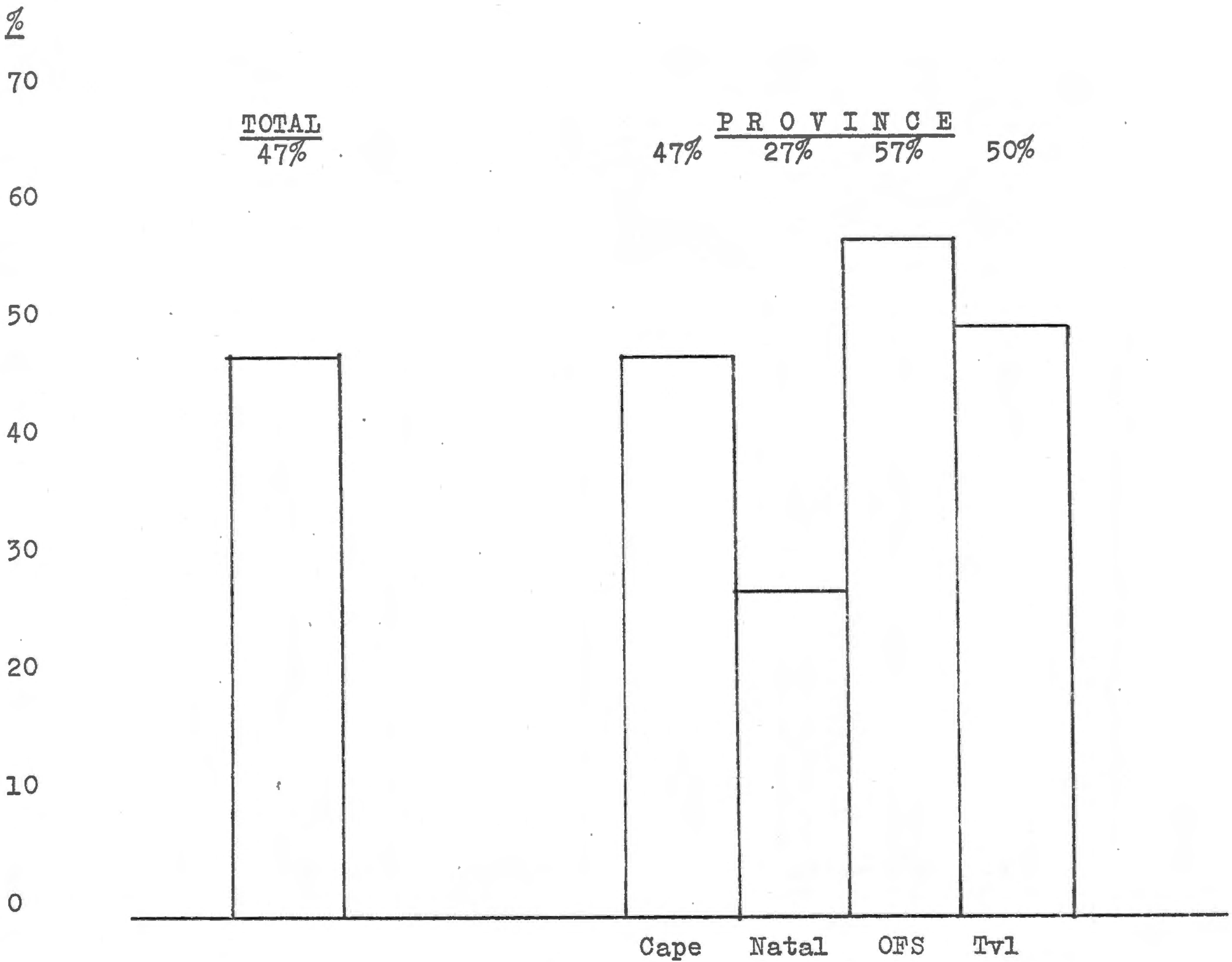
QUESTION: Do you agree or disagree that it should be made easier to obtain a legal abortion in South Africa?

ANSWER: Agree.



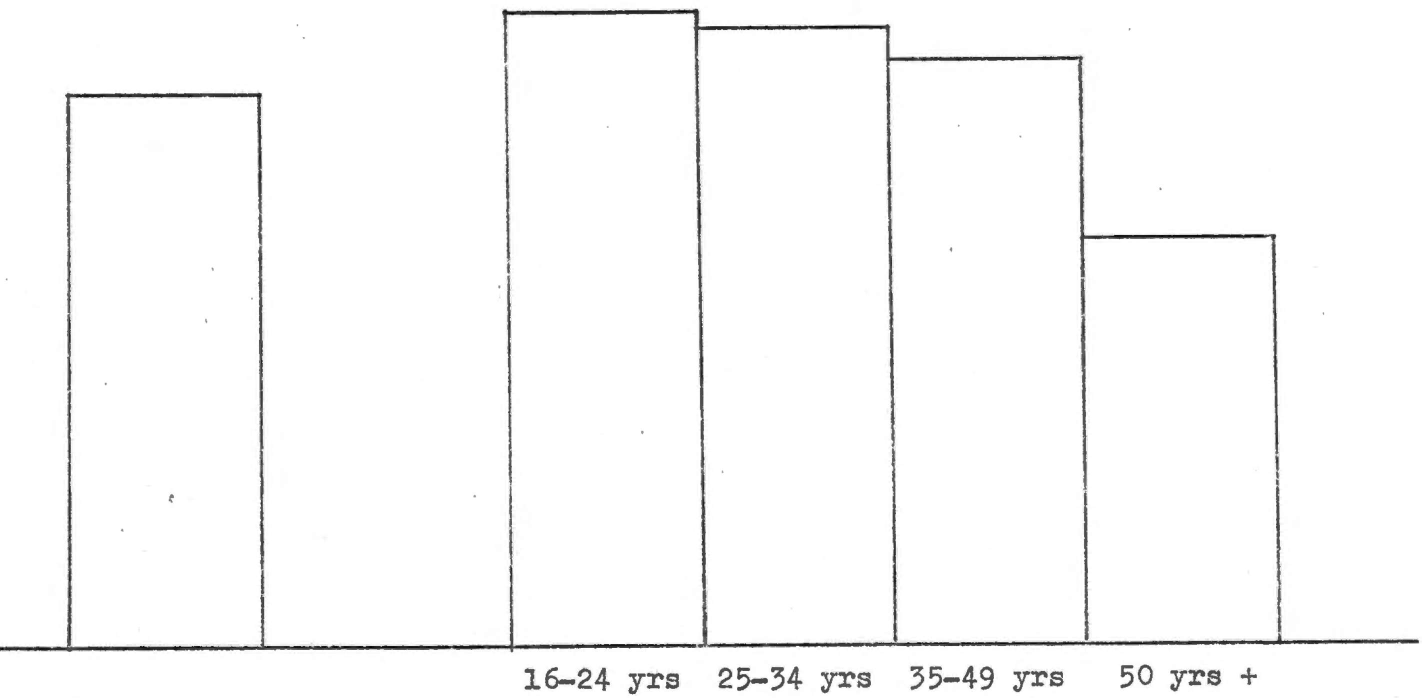
QUESTION: Do you agree or disagree that it should be made easier to obtain a legal abortion in South Africa?

ANSWER: Disagree.



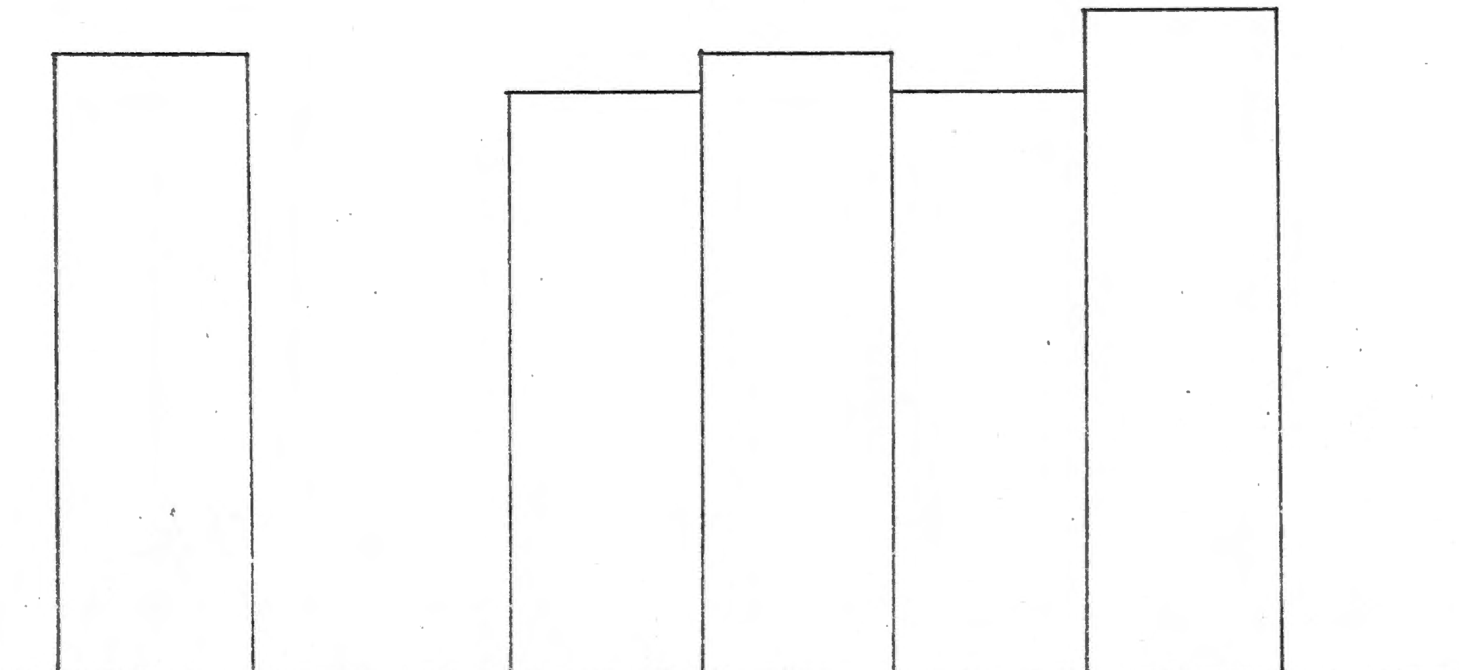
QUESTION: Do you agree or disagree that it should be made easier to obtain a legal abortion in South Africa?

ANSWER: Agree.



QUESTION: Do you agree or disagree that it should be made easier to obtain a legal abortion in South Africa?

ANSWER: Disagree.



APPENDIX B

PROGRESSIVE CHANGES IN WORLD ABORTION LEGISLATION

INDICATIONS FOR THERAPEUTIC ABORTION ARE MARKED ACCORDING TO THE FOLLOWING KEY

ABORTION PROHIBITED

ABORTION PERMITTED ONLY TO SAVE THE LIFE OF THE MOTHER

ABORTION PERMITTED TO SAVE THE 'HEALTH' OF THE MOTHER, I.E. MEDICAL AND PSYCHIATRIC INDICATIONS

ABORTION PERMITTED FOR:

(a) 'Health' (medical and psychiatric)
(b) Eugenic grounds
(c) Humanitarian grounds

ABORTION PERMITTED FOR:

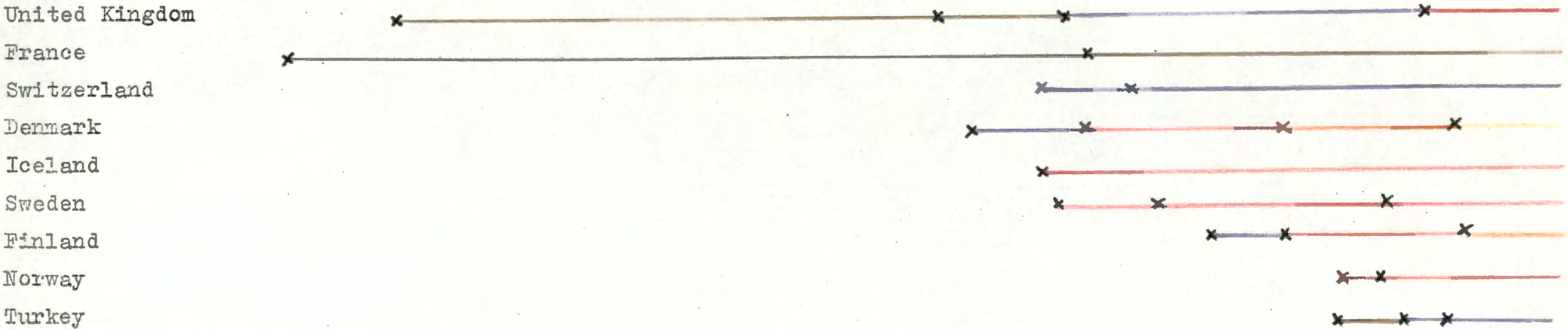
(a) 'Health' (medical and psychiatric)
(b) Eugenic grounds
(c) Humanitarian grounds
(d) Medico-social grounds

ABORTION PERMITTED FOR:

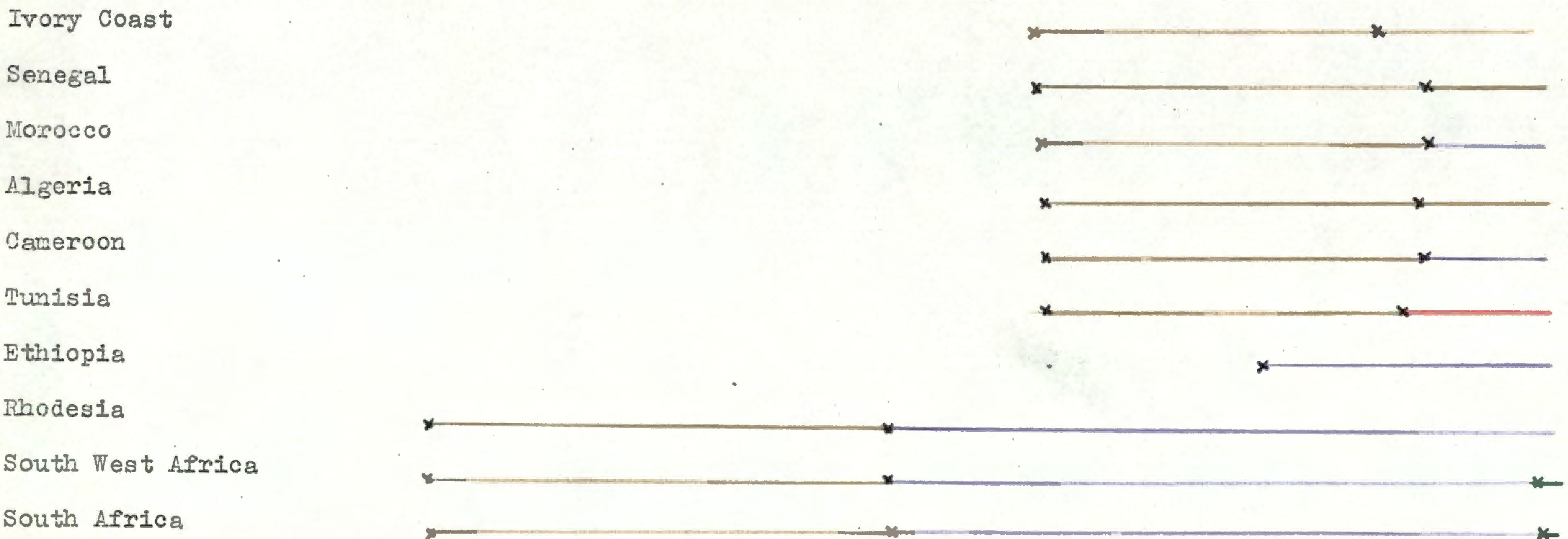
(a) 'Health' (medical and psychiatric)
(b) Eugenic grounds
(c) Humanitarian grounds
(d) Medico-social grounds
(e) Social grounds

ABORTION PERMITTED ON REQUEST

EVOLUTION OF ABORTION LEGISLATION IN EUROPE 1810 - 1975



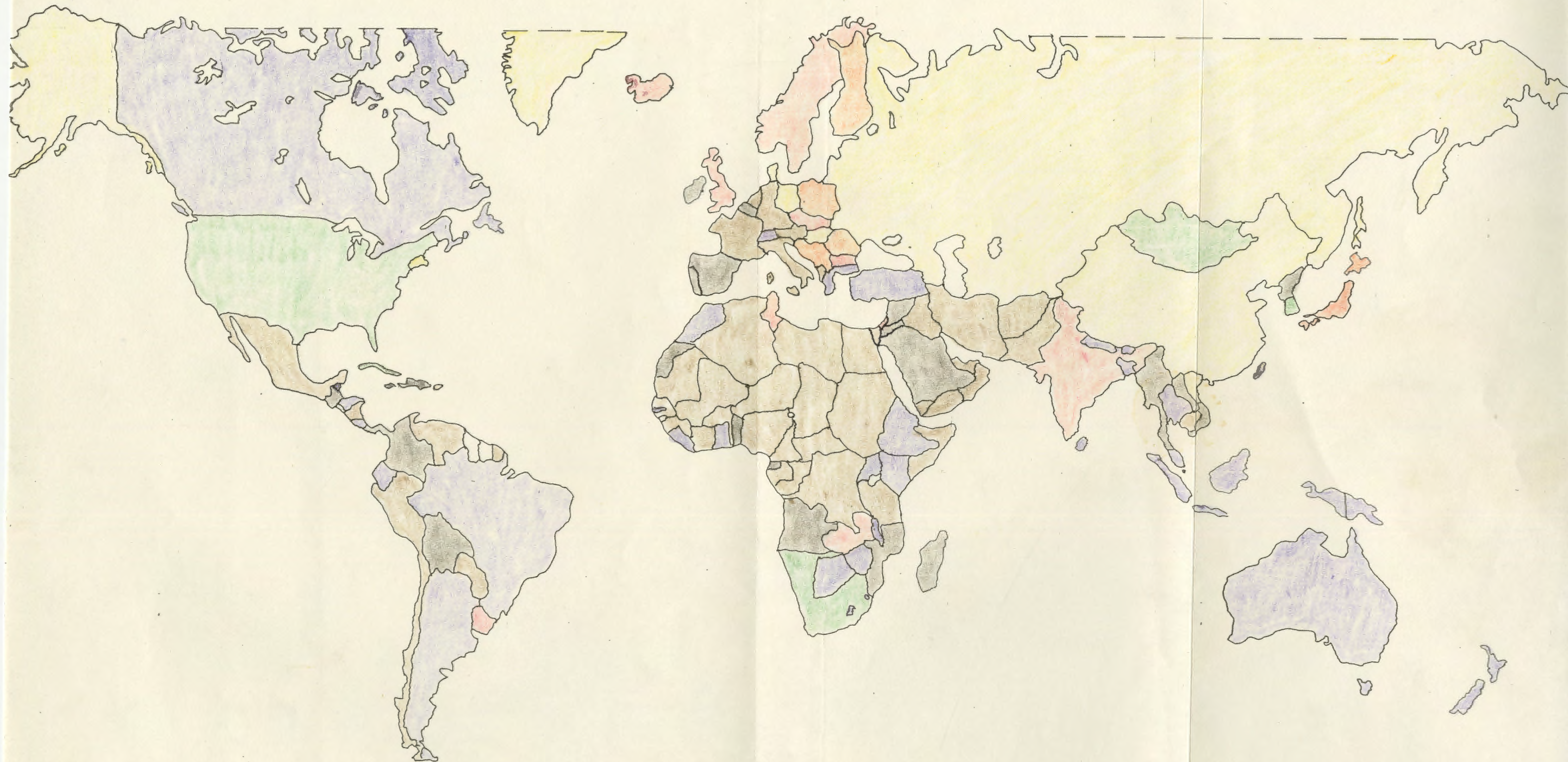
EVOLUTION OF ABORTION LEGISLATION IN AFRICA 1860 - 1975

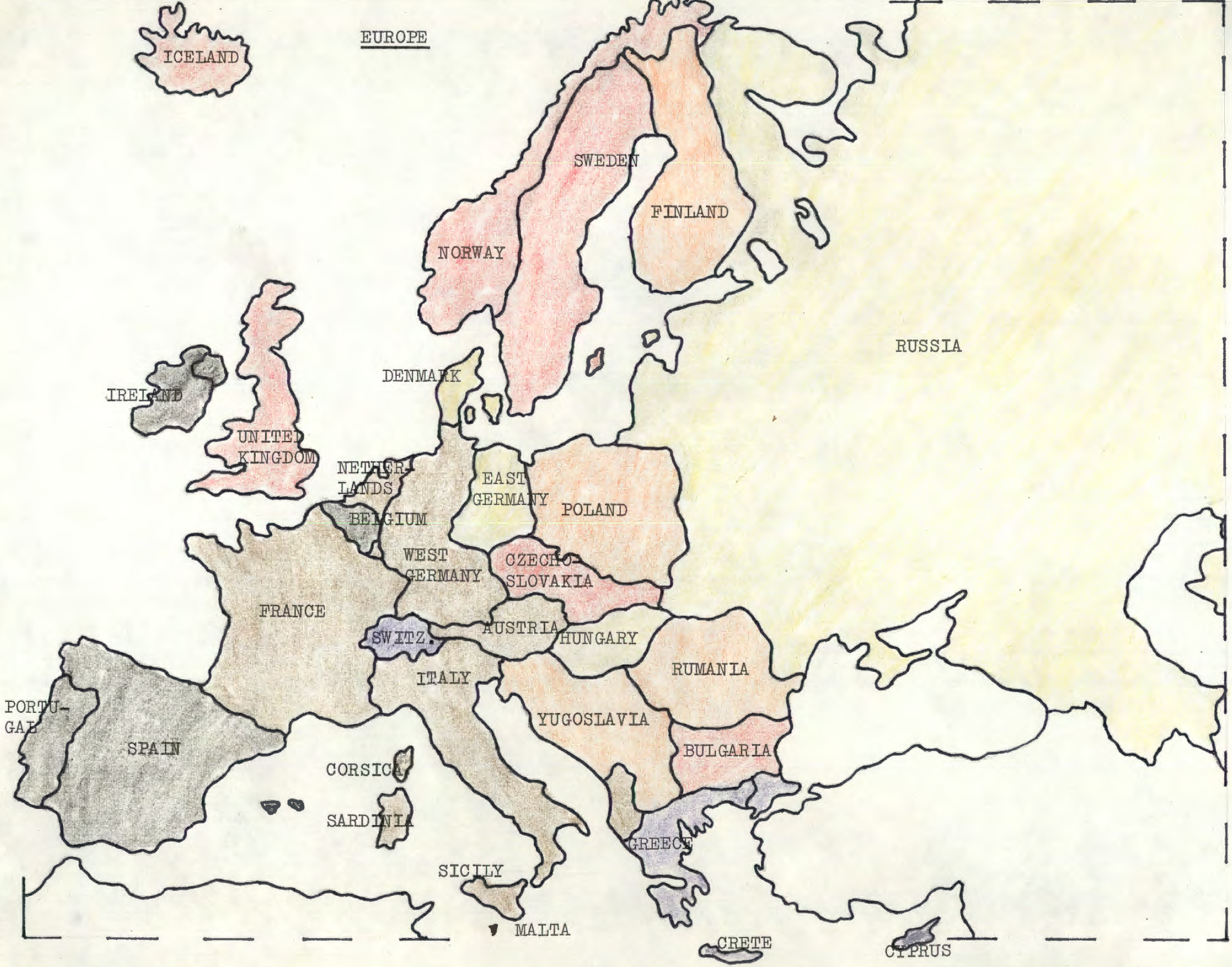


APPENDIX C

MAPS OF WORLD ABORTION LEGISLATION

WORLD ABORTION LEGISLATION

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UNITED KINGDOM
NETHER-LANDS
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POLAND
WEST GERMANY
CZECHO-SLOVAKIA
FRANCE
SWITZ.
AUSTRIA
HUNGARY
RUMANIA
ITALY
PORTU-GAL
SPAIN
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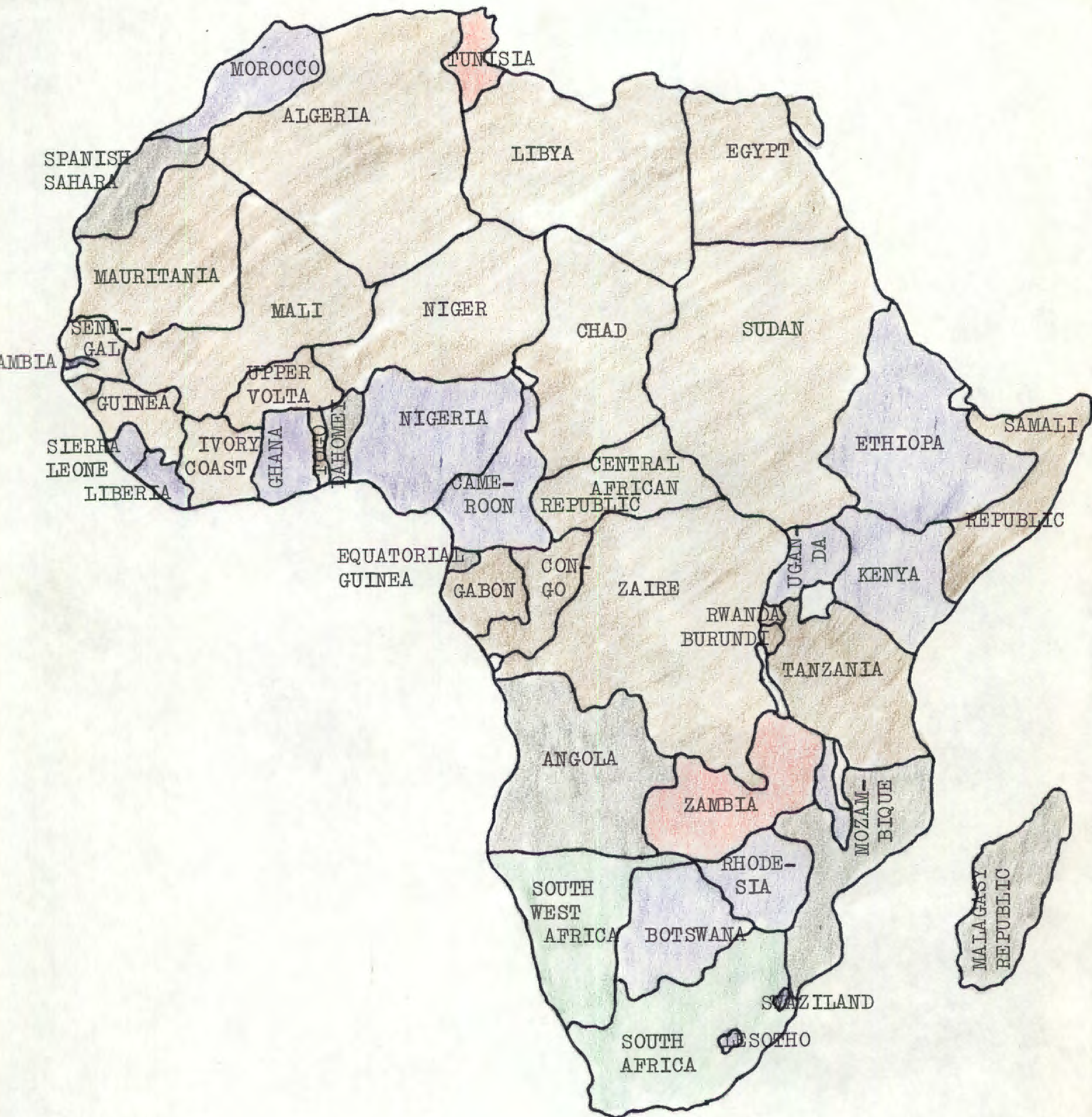
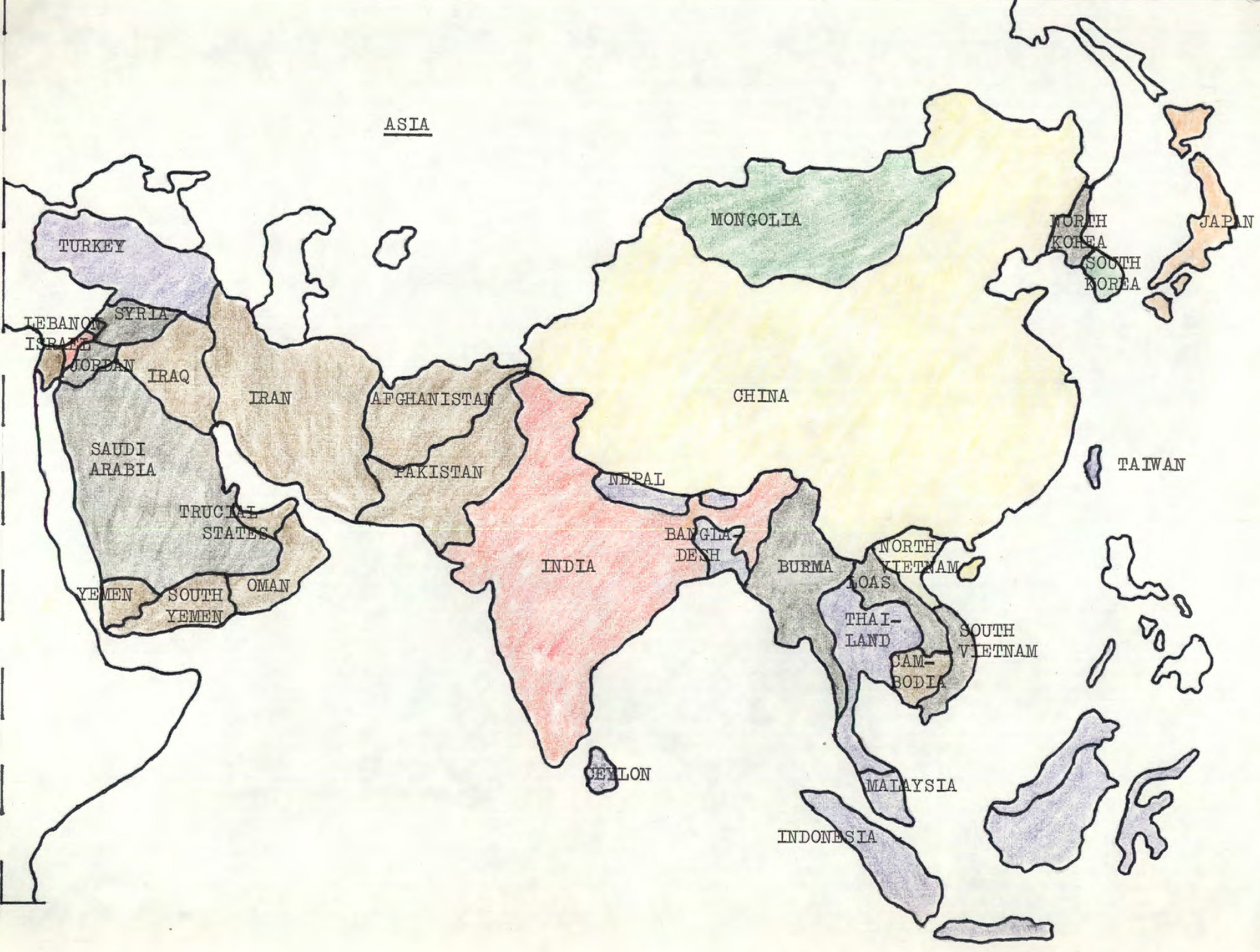
GREECE
SICILY
MALTA
CRETE
CYPRUS

AFRICA



SOUTH AMERICA

NORTH AMERICA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IRAQ
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TRUCIAL STATES
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SOUTH YEMEN
AFGHANISTAN
PAKISTAN
MONGOLIA
CHINA
NORTH KOREA
SOUTH KOREA
JAPAN
TAIWAN
NEPAL
INDIA
BANGLA-DESH
BURMA
NORTH VIETNAM
LOAS
THAI-LAND
CAM-BODIA
SOUTH VIETNAM
CEYLON
MALAYSIA
INDONESIA

APPENDIX D

CODING OF THE WHITE PUNCH CARDS

CODING OF THE WHITE CARDS

Data collected from both the interview with the psychiatric social worker and the consultant psychiatrist.

Written on the Card

Name
Date of Birth
Marital Status
Religion

Hospital No.
Ethnic Group

Code

1. Referred for sterilization
2. Referred for termination
3. Sterilization recommended
4. Termination recommended
5. Age under 14 years
6. 14 years but under 16 years
7. 16 years but under 18 years
8. 18 years but under 21 years
9. 21 years but under 30 years
10. 30 years but under 39 years
11. 39 years and above
12. White
13. Coloured
14. Indian
15. African
16. Socio-Economic Class I
17. Socio-Economic Class II
18. Socio-Economic Class III
19. Socio-Economic Class IV
20. Socio-Economic Class V
21. Socio-Economic Class VI
22. Presented before the 8th week of pregnancy
23. Presented after the 8th week but before the 12th week of pregnancy
24. Presented after the 12th week but before the 16th week of pregnancy

25. Presented after the 16th week but before the 20th week of pregnancy
26. Presented from the 20th week of pregnancy
27. Documented previous or current psychiatric treatment received/or being received
28. Referred for psychiatric treatment as a result of the termination interview
29. Previous termination (legal or illegal)
31. Previous illegitimate birth (whether kept or adopted)
32. Nulliparous
33. Less than 4 children
34. 4 but less than 6 children
35. 6 or more children
36. Married
37. Divorced
38. Separated
39. Rape (reported to the police)
41. Rape (not reported to the police)
42. Promiscuous relationship (including mentally defective)
43. Longstanding relationship
44. Parental involvement
45. Has never used contraception
46. Used contraception previously but gave it up
47. Failed contraception
48. Rape cases (all whether reported or not) } some overlap
49. Mentally retarded (IQ under 80) }
51. Previous sexual partner(s)
52. Reputed father first and only sexual partner
53. IQ less than 50
54. IQ 50 but less than 60
55. IQ 60 but less than 70
56. IQ 70 but less than 80
57. No education
58. Primary school
59. High school
61. Matriculation
62. University
63. Behaviour/academic difficulties at school

64. Broken work record
65. Stable work record
66. Illegitimate, adopted or fostered as a child
67. Eldest child
68. Youngest child
A. Only child
B. Attitude towards the pregnancy (overlap) Denial
C. Anger
D. Guilt
E. Hurt
F. Accepting
G. Hysterical
H. Hostile towards men
I. Considered ambivalent
J. Good relationship with mother or mother substitute
K. Good relationship with father or father substitute
L. Socializes well
M. Disrupted family background
N. Documented formal psychiatric illness in the family
O. Closer to mother than father
P. Closer to father than mother
Q. Attended with reputed father
R. Stable self description given of self prior to the pregnancy
S. Threatens to commit suicide if not terminated
T. Threatens illegal or self abortion if not terminated
U. Male partner showing concern and support
V. Male partner not showing concern or support
W. No male partner
X. Attended our follow-up
Z. Referred elsewhere for follow-up
BB. Good reaction after operation as expressed by patient, e.g. relief
CC. Poor reaction after operation as expressed by patient, e.g. guilt

DD. Those refused - Stated she will get married

FF. Stated she will have the baby adopted

GG. Stated she will keep the baby alone

A. Reported abortion elsewhere

E. Reported 'miscarriage'

I. Confused and does not know what to do

O. Decision unknown

U. Inappropriate referrals - medical and rape cases (those reported)

Y. Previous suicide attempt

A P P E N D I X   E

GROUPING OF INITIAL PRESENTING DATA

Data was Grouped According to the Following Categories

1. Total number of cases seen
2. Total referred for termination

   Total referred for sterilization
3. Recommendations

   Termination and sterilization recommended

   Termination and sterilization not recommended

   Purely termination recommended

   Purely termination not recommended
4. Age Distribution

   14 years

   14 years but under 16 years

   16 years but under 18 years

   18 years but under 21 years

   21 years but under 30 years

   30 years but under 39 years

   39 years and above
5. Ethnic Group

   White

   Coloured

   Indian

   African
6. Socio-Economic Class

   Social Class I

   Social Class II

   Social Class III

   Social Class IV

   Social Class V

   Social Class VI
7. Duration of Pregnancy

   Presented before the 8th week of pregnancy

   Presented after the 8th week but before the 12th week of pregnancy

   Presented after the 12th week but before the 16th week of pregnancy

   Presented after the 16th week but before the 20th week of pregnancy

Presented from the 20th week of pregnancy

8. Documented Previous or Current Psychiatric Treatment
9. Referred for Psychiatric Treatment
10. Previous Termination

Legal

Illegal

11. Previous Illegitimate Birth
12. Parity

Nulliparous

Less than 4 children

4 but less than 6 children

6 or more children

13. Marital Status

Unmarried

Married

Divorced

Separated

Widowed

14. Type of Relationship

Rape (reported to the police)

Rape (not reported to the police)

Promiscuous relationship

Longstanding relationship

15. Parental Involvement
16. Use of Contraception

Has never used contraception

Used contraception previously and gave it up

Failed contraception

Rape cases (all reported or not)) overlap

Mentally retarded (IQ under 80))

17. Sexual Experience

Previous sexual partner(s)

Reputed father first and only sexual partner

18. IQ Scores of the Mentally Retarded

IQ under 50

IQ 50 but under 60

IQ 60 but under 70

IQ 70 but under 80

19. Educational Level
    - No education
    - Primary school
    - High school
    - Matriculation
    - University
20. Behaviour/Academic Difficulties at School
21. Work Performance
    - Broken work record
    - Stable work record
    - Still studying and never worked
22. Illegitimate, Adopted or Fostered as a Child
23. Position in the Family
    - Only child
    - Eldest child
    - Youngest child
    - Other position
24. Attitude towards the Pregnancy (these categories only)
    - Denial
    - Anger
    - Guilt
    - Hurt
    - Accepting
    - Hysterical
    - Hostile towards men
25. Considered Ambivalent
26. Relationship with Parents
    - Good relationship with mother
    - Good relationship with father
27. Socializes Well
28. Disrupted Family Background
29. Documented Psychiatric Illness in the Family
30. Parental Preference
    - Closer to mother than father
    - Closer to father than mother
31. Attended with Reputed Father
32. Stable Self Description of Self given Prior to Pregnancy

33. Threats if not Terminated

To commit suicide

To seek illegal abortion

No threats

34. Support Shown by Male Partner

Male partner showing concern and support

Male partner not showing concern and support

No male partner

35. Follow-Up

Attended our follow-up

Did not attend our follow-up

Referred elsewhere for follow-up

36. Reaction after Operation as Given by Patient

Good reaction, e.g. relief

Poor reaction, e.g. guilt

Did not attend

37. Stated Intention of those not Terminated

To get married

To have the baby adopted

To keep the baby alone

Reported abortion elsewhere

Reported 'miscarriage'

Does not know what to do

Decision now known

38. Inappropriate Referral

Rape (those reported to the police)

Medical cases

39. Previous Suicide Attempts

Prior to pregnancy

During this pregnancy

40. Religion

Jewish

Moslem

Roman Catholic

Anglican

Dutch Reformed

Methodist

40. <u>Religion</u> (Continued)

Presbyterian

Congregational

Other Christian

Not known

A P P E N D I X F

DEFINITIONS OF SOME OF THE CATEGORIES OF INITIAL PRESENTATION DATA

Since some of the cited categories are not mutually exclusive, specific definitions were used as follows:

Social Economic Class

The patient's social class was rated according to her father's occupation if she was unmarried, widowed or divorced and according to her husband's occupation if married. The rating scale used was that used by the University of Cape Town Child Guidance Clinic. It is divided into six classes with the following occupations being found in each class division.

Class I: Traditional aristocracy, millionaires, cabinet ministers, chancellors and principals of universities, managing directors or chairmen of boards of nation-wide or international companies.

Class II: Professionals, salaried executives, owners of large firms, operators of moderate sized enterprises, students of universities and colleges, prosperous farmers and landowners.

Class III: Small business men, small farmers, clerical workers, white-collar workers, semi-professionals.

Class IV: Skilled workers, qualified tradesmen, apprentices.

Class V: Semi-skilled workers.

Class VI: Unskilled workers, permanently unemployed, poor Whites.

Married

This included:

(a) Those legally married.
(b) Those married by Moslem rites only.
(c) Common law unions (i.e. with the patient referring to her partner as her 'husband').

Promiscuous Relationships

This included:

(a) 'One night stands'.
(b) Sexual intercourse on the rebound.
(c) More than one sexual partner.
(d) No ongoing relationship with the reputed father.
(e) Mentally retarded.

Longstanding Relationships

This included:

(a) An ongoing relationship with the reputed father.
(b) Those who were engaged or 'going steady'.

It implied an agreement between the patient and her partner, but did not include common law unions.

Parental Involvement

This included:

(a) Either one or both parents/guardians being aware of the pregnancy, i.e. they have been told.
(b) Those parents showing concern/interest, positive and/or negative.
(c) Those patients who are physically present or are definitely giving support in the background.

Educational

This included:

(a) Patients who had completed a certain division or had left school then, e.g. High School - Std. VII.
(b) Patients who at presentation fell into one of these categories.

Behavioural and/or Academic Difficulties at School

This included:

(a) Difficulty in separating and going to school.
(b) Difficulty in socializing at school.
(c) Difficulty in relating to teachers.
(d) Expulsion from school.
(e) Truancy.
(f) Difficulty in keeping up with school work.
(g) Over anxious about school work.
(h) Those who remember school only as a negative experience.

Broken Work Record

This included:

(a) Having a number of jobs over a short period of time.
(b) Being sacked from place of employment or walking out.

Stable Work Record

This included:

(a) Consistent employment.
(b) Being able to give verifiable explanations for changes in employment, e.g. being asked to leave after an amalgamation.

Illegitimate, Adopted or Fostered as a Child

This included:

(a) Reference to the birth status of the patient herself.
(b) Does not include children from common law unions but where such a union has not existed, the child was considered to be illegitimate.

Attitude Towards the Pregnancy

This included:

(a) Expressed feelings of the patient.
(b) Subjective impressions of the interviewer.

Considered Ambivalent

This included:

(a) Patients expressing overt ambivalence.
(b) Patients who are in conflict as to what to do for the best.

Good Relationship with Parents

This included:

(a) The patient overtly stated that it was a good relationship.
(b) The patient described her parents in a positive light.
(c) The patient being able to communicate with and confide in her parents and find them understanding.

Socializes Well

This included:

(a) Age appropriate socializing.
(b) The patient not being either unduly introverted and withdrawn, or extroverted.
(c) Subjective impression gained from the patient as she describes her peer relationships.

Disrupted Family Background

This included:

(a) Divorced or separated parents.
(b) Death of one or both parents prior to the patient turning 18 years.
(c) The patient being institutionalized or placed in need of care as a child.

Disrupted Family Background (Cont.)

(d) Brought up by relatives and not parents.

(e) African families separated by the migratory labour system.

(f) Illegitimate, adopted or fostered children whose families fall into any of the above categories.

Parental Preference

This included:

(a) The patient overtly expressing preference of attachment to either parent.

(b) From the way the patient described her parents, a subjective preference may have been shown.

(c) Those who confide in one parent to the exclusion of the other.

Self Description (Stable prior to this pregnancy)

This included:

(a) Being able to evaluate her own positive and negative attributes.

(b) Seeing herself objectively.

(c) Clinically the patient does not present with past personality or behavioural problems.

Male Partner not Showing Concern or Support

This included:

(a) Those male partners who knew about the pregnancy and did not give support.

(b) Longstanding relationship where the patient did not confide in her partner, and he therefore could not give support, but with whom the patient was still involved.

No Male Partner

This included:

(a) Deserted by male partner.

(b) Death of the partner.

(c) 'One night stands'.

(d) All rape cases - whether reported or not.

(e) Those who are mentally retarded.

(f) Those who broke off the relationship prior to the discovery of the pregnancy.

APPENDIX G

FOLLOW-UP QUESTIONNAIRES ON EMOTIONAL RESPONSES AND DEMOGRAPHIC DATA

Code No:

Name:
Date Seen:
Ethnic Group:
Age:

Questionnaire for those Terminated (and Sterilized)
(to be completed by interviewer)

1. Does the patient feel the correct decision was made? Is she still confused about the issue?

2. Support during hospitalization:

   (a) Felt hospital staff were supportive.
   (b) Felt parents were supportive.
   (c) Felt peers were supportive.
   (d) Patient left to support herself on her own.
   (e) Felt reputed father was supportive.

3. Would the patient have preferred more counselling before the decision?

4. Further pregnancies or abortions.

5. Memory of hospitalization before the abortion (and sterilization):

   (a) Depressed
   (b) Guilty
   (c) Denial of feelings
   (d) Considered staff helpful

6. Memory of hospitalization after the abortion (and sterilization):

   (a) Depressed
   (b) Guilty
   (c) Denial of feelings
   (d) Considered staff helpful

7. Does the patient feel she has learnt by the experience?

   (a) Positive experience
   (b) Negative experience

8. Attitude to abortion now:

   (a) Anti-abortion --> pro-abortion
   (b) Pro-abortion --> anti-abortion
   (c) Always been pro-abortion
   (d) Always been anti-abortion

9. Use of contraception now:

   (a) Has not bothered about contraception
   (b) Used contraception erratically
   (c) Has been on contraception continually

10. Effect on male relationships:

   (a) Still involved with reputed father
   (b) Engaged or married to reputed father
   (c) Successful relationship with reputed father
   (d) Engaged or married to someone else
   (e) Steady boyfriend with sexual intercourse
   (f) Successful relationship with someone else
   (g) He knows about the abortion
   (h) Dating casually without sexual intercourse
   (i) Sticks to platonic relationships
   (j) More wary or scared of men

11. Resettlement back into society:

   (a) Returned to same school
   (b) Changed schools
   (c) Fall in academic record - school/university
   (d) Rise in academic record - school/university
   (e) Same academic record - school/university
   (f) Returned to same job/university
   (g) Changed jobs, courses, left university
   (h) Has held a number of jobs

12. Change in accommodation:

   (a) Stayed with parents throughout
   (b) Lived alone throughout
   (c) Married - living with husband
   (d) Lived with peers throughout

(e) Living with parents now
(f) Went upcountry to friends or relatives
(g) Living alone now

13. Effect on interpersonal relationships:

(a) Parents did not know about the abortion
(b) Siblings did not know about the abortion
(c) Parental acceptance throughout
(d) Sibling acceptance throughout
(e) Acceptance by reputed father throughout
(f) Settled back into same peer group
(g) Changed peer group
(h) Withdrawn, isolated, anti-social initially
(i) Withdrawn, isolated, anti-social now

14. Religious conflict:

(a) Has become more anti-religious
(b) Has become more religious
(c) No change in religious feelings

15. Further counselling or treatment sought:

(a) Psychiatric - after abortion
(b) General practitioner - after abortion
(c) Welfare agency - after abortion

16. Use of self medication:

(a) Increased use of tranquillizers
(b) Increased use of tobacco
(c) Increased use of alcohol
(d) Increased use of dagga or other drugs

17. Physical health since:

(a) Increase in existing symptoms
(b) Menstrual disorders
(c) Side effects after abortion, needing medical attention

18. Image of self now

19. Further comments

The following is applicable to those who had an abortion and sterilization.

1. Do you regret the sterilization?
2. Why?
3. Why was sterilization sought rather than other means of contraception?
4. Did you want the sterilization or was someone else pushing for it?
   (a) Doctors?
   (b) Husband?
5. Did you have a sterilization operation in order to be terminated?
6. Who advised you about the sterilization operation?
7. Was the operation fully explained to you beforehand?
8. Do you feel it was a hurried decision?

Code No:

<u>This Information will be treated with the Strictest Confidentiality</u>

Please would you fill in this questionnaire which would be most helpful to us.

Please use the various words and adjectives as you would in everyday life.

The scale to be used is as follows:

1	2	3	4	5
not at all	to a small degree	to a moderate degree	to a considerable degree	extremely

1. Your immediate reaction after you had had the abortion (and sterilization).

a.	Depression	1	2	3	4	5
b.	Relief	5	4	3	2	1
c.	Regret	5	4	3	2	1
d.	Embarrassment	1	2	3	4	5
e.	Guilt	5	4	3	2	1
f.	Anxiety	1	2	3	4	5
g.	Shame	1	2	3	4	5
h.	Fear of disapproval	5	4	3	2	1
i.	Anger	1	2	3	4	5
j.	Happiness	5	4	3	2	1
k.	Doubt	5	4	3	2	1
l.	Disappointment in self	1	2	3	4	5
m.	Denial of feelings	5	4	3	2	1

2. How do you feel now about the abortion (and sterilization).

a.	Depression	1	2	3	4	5
b.	Relief	5	4	3	2	1
c.	Regret	1	2	3	4	5
d.	Embarrassment	1	2	3	4	5
e.	Guilt	5	4	3	2	1
f.	Anxiety	5	4	3	2	1
g.	Shame	1	2	3	4	5

h.	Fear of disapproval	5	4	3	2	1
i.	Anger	1	2	3	4	5
j.	Happiness	1	2	3	4	5
k.	Doubt	5	4	3	2	1
l.	Disappointment in self	1	2	3	4	5
m.	Denial of feeling	5	4	3	2	1

Code No:

Name:

Date Seen:

Ethnic Group:

Age:

Questionnaire for those Not Recommended for Abortion (and Sterilization)
(To be completed by the interviewer)

1. Does the patient feel the correct decision was made?
2. Does she feel she would have preferred more counselling after the decision?
3. Body image during pregnancy
   (a) Accepted the effects of hormonal changes
   (b) Frightened by the effects of hormonal changes
4. Attempted suicide as threatened after refusal for abortion

   Attempted illegal abortion as threatened after refusal for abortion

   Successful illegal abortion
5. Outcome of pregnancy
   (a) Baby adopted
   (b) Depressed after adoption - remorse, depression, mourning
   (c) Got married to reputed father
   (d) Kept the baby
   (e) Acceptance of baby if kept
   (f) Rejection of baby if kept
   (g) Coping with baby and finances
   (h) 'Miscarriage' reported
6. Support during pregnancy and confinement
   (a) Hospital staff supportive
   (b) Parents supportive
   (c) Reputed father supportive
   (d) Peers supportive
   (e) Left to support herself alone

7. Change in accommodation
   (a) Went into home for unmarried mothers
   (b) Stayed with parents throughout
   (c) Lived alone throughout
   (d) Living with parents now
   (e) Lived with peers throughout
   (f) Went upcountry
   (g) Living alone now

8. Attitude to home for unmarried mothers
   (a) Positive experience - felt supported and secure
   (b) Negative experience - felt isolated

9. Attitude towards the pregnancy
   (a) Disgusted
   (b) Guilty
   (c) Ashamed
   (d) Angry
   (e) Accepting
   (f) Maternal

10. Memory of hospitalization and feelings while there
    (a) Depressed
    (b) Ashamed/guilty
    (c) Envious of other mothers keeping their babies

11. Resettlement back into society
    (a) Returned to same school
    (b) Changed schools
    (c) Fall in academic record - school/university
    (d) Same academic record - school/university
    (e) Rise in academic record - school/university
    (f) Returned to same job/university
    (g) Changed jobs, courses, left university

12. Effect on relationship with the opposite sex
    (a) Still involved with reputed father
    (b) Engaged or married to reputed father
    (c) Successful relationship with reputed father
    (d) Engaged to someone else

(e) Steady boyfriend with sexual intercourse
(f) Successful relationship with someone else
(g) He knows about the pregnancy
(h) Dating casually without sexual intercourse
(i) Sticks to platonic relationships
(j) More wary or scared of men

13. Use of contraception now
(a) Has not bothered about contraception since the birth
(b) Has used contraception continually since birth
(c) Has used contraception erractically since birth

14. Attitude towards abortion
(a) Pro-abortion → anti-abortion
(b) Anti-abortion → pro-abortion
(c) Always been pro-abortion
(d) Always been anti-abortion

15. Further abortions or pregnancies

16. Effect on interpersonal relationships
(a) Parents did not know about the pregnancy
(b) Siblings did not know about the pregnancy
(c) Parental acceptance throughout
(d) Sibling acceptance throughout
(e) Acceptance by reputed father throughout
(f) Settled back into same peer group
(g) Changed peer group
(h) Withdrawn, isolated, anti-social initially
(i) Withdrawn, isolated, anti-social now.

17. Religious conflict
(a) Has become more anti-religion
(b) Has become more religious
(c) No change in religious feelings

18. Further counselling or treatment sought
(a) Psychiatric - after abortion refused
(b) General practitioner - after abortion refused (including ante-natal care)
(c) Welfare agency - after abortion refused

19. Use of self medication
    (a) Increased use of tranquillizers
    (b) Increased use of tobacco
    (c) Increased use of alcohol
    (d) Use of dagga or other drugs

20. Physical health since birth
    (a) Increase in pre-existing symptoms
    (b) Difficult labour
    (c) Repulsed by labour
    (d) Menstrual disorders

21. Self image of self now

22. Other comments

The following is applicable to those who were refused both an abortion and sterilization:

1. Do you regret not being sterilized?

2. Do you still wish to be sterilized?

3. Why was sterilization and not other contraceptive measures used?

4. Are you glad you were not sterilized?

5. Did you ask to be sterilized in order to have an abortion?

6. Was someone else pushing for the sterilization -
    (a) Doctors?
    (b) Husband?

Code No:

<u>This Information will be treated with the Strictest Confidentiality</u>

Please would you fill in this questionnaire which would be most helpful to us.

Please use the various words and adjectives as you would in everyday life.

The scale to be used is as follows:

1	2	3	4	5
not at all	to a small degree	to a moderate degree	to a considerable degree	extremely

1. Your immediate reaction on being refused an abortion (and sterilization)

a.	Depression	1	2	3	4	5
b.	Relief	5	4	3	2	1
c.	Regret	5	4	3	2	1
d.	Embarrassment	1	2	3	4	5
e.	Guilt	5	4	3	2	1
f.	Anxiety	1	2	3	4	5
g.	Shame	1	2	3	4	5
h.	Fear of disapproval	5	4	3	2	1
i.	Anger	1	2	3	4	5
j.	Happiness	5	4	3	2	1
k.	Doubt	5	4	3	2	1
l.	Disappointment in self	1	2	3	4	5
m.	Denial of feelings	5	4	3	2	1

2. How do you feel now about having been refused an abortion (and sterilization)?

a.	Depression	1	2	3	4	5
b.	Relief	5	4	3	2	1
c.	Regret	1	2	3	4	5
d.	Embarrassment	1	2	3	4	5
e.	Guilt	5	4	3	2	1
f.	Anxiety	5	4	3	2	1
g.	Shame	1	2	3	4	5

h.	Fear of disapproval	5	4	3	2	1
i.	Anger	1	2	3	4	5
j.	Happiness	1	2	3	4	5
k.	Doubt	5	4	3	2	1
l.	Disappointment in self	1	2	3	4	5
m.	Denial of feelings	5	4	3	2	1

A P P E N D I X   H

CODING OF YELLOW PUNCH CARDS

CODING OF THE YELLOW CARDS

Data collected by the psychiatric social worker at 12 to 18 months after the patient's initial presentation.

Written on the Card

Code Number: Ethnic Group:

Name:

Marital Status:

Religion:

Code

1. Termination performed in South Africa at Groote Schuur Hospital (in both psychiatric and medical indications).
2. Termination not performed.
3. Termination performed elsewhere (backstreet abortion, abortion overseas, legal abortion in South Africa prior to the Abortion and Sterilization Act 2/75).
4. Sterilization performed.
5. Sterilization not performed.
6. Feels that the doctor at Groote Schuur Hospital made the correct decision.
7. Still confused as to whether the decision was correct.
8. Would have preferred more counselling beforehand.
9. Would have liked more counselling after the decision.
10. Accepted body changes.
11. Frightened of body changes.
12. Attempted suicide after refusal for abortion.
13. Attempted illegal abortion after refusal for legal abortion.
14. Successful illegal abortion after refusal for legal abortion.
15. 'Miscarriage' reported.
16. Baby adopted.
17. Depressed after adoption, mourning, remorse.
18. Got married to reputed father after refusal for abortion.
19. Got married to reputed father after the birth.
20. Kept the baby.
21. Acceptance of the baby if kept.
22. Rejection of the baby if kept.

23. Coping with baby and finances.
24. Further abortion or pregnancy.
25. Hospital staff supportive.
26. Parents supportive.
27. Reputed father supportive.
28. Peers supportive.
29. Left to support herself on her own.
31. Negative experience.
32. Positive experience.
33. In hospital before abortion - depressed.
34. In hospital before abortion - guilty.
35. Immediately after abortion in hospital - depressed.
36. Immediately after abortion in hospital - guilty.
37. Went into home for unmarried mothers.
38. Stayed with parents/relatives throughout.
39. Now living with parents/relatives.
41. Lived alone throughout and/or now.
42. Married - living with husband or peers.
43. Went upcountry to relatives or friends.
44. Positive experience - felt supported and secure in home for unmarried mothers.
45. Negative experience - felt isolated in home for unmarried mothers.
46. Anti-abortion -> pro-abortion.
47. Pro-abortion -> anti-abortion.
48. Always been pro-abortion but not on demand.
49. Always been anti-abortion.
51. Abortion on demand.
52. Attitude towards the abortion - disgusted.
53. Attitude towards the abortion - guilty.
54. Attitude towards the abortion - ashamed.
55. Attitude towards the abortion - angry.
56. Attitude towards the abortion - accepting.
57. Attitude towards the abortion - maternal.
58. Memory of hospitalization of those refused abortion - depressed.
59. Memory of hospitalization of those refused abortion - ashamed/guilty.

61. Memory of hospitalization of those refused abortion - envious of mothers keeping their babies.
62. Has not used contraception since birth/abortion.
63. Has used contraception continually since birth/abortion.
64. Contraception used erratically.
65. Still involved with reputed father.
66. Engaged or married to reputed father.
67. Successful relationship with reputed father.
68. Engaged or married to someone else.
A. He knows about the pregnancy/abortion.
B. Successful relationship with someone else.
C. Dating casually without sexual intercourse.
D. Steady boyfriend with sexual intercourse.
E. Sticks to platonic relationships.
F. More wary or scared of men.
G. Changed school/university/job.
H. Returned to same school/university/job.
I. Fall in academic record.
J. Rise in academic record.
K. Same academic record.
L. Has held a number of jobs since abortion/pregnancy.
M. Parents did not know about abortion/pregnancy.
N. Siblings did not know about abortion/pregnancy.
O. Parental acceptance throughout.
P. Sibling acceptance throughout.
Q. Acceptance by reputed father throughout.
R. Settled back into same peer group.
S. Changed peer group.
T. Withdrawn, isolated, anti-social initially.
U. Withdrawn, isolated, anti-social now.
V. Has become more anti-religious.
W. Has become more religious.
X. No change in religious feelings.
Y. Psychiatric counselling after recommendation or refusal.
Z. G.P. counselling after recommendation or refusal.
BB. Welfare counselling after recommendation or refusal.
CC. Increased use of tranquillizers after recommendation or refusal.

DD. Increased use of tobacco.

FF. Increased use of alcohol.

GG. Increased use of dagga or other drugs.

A. Increase in existing symptoms.

E. Menstrual disorders.

I. Side effects after abortion requiring medical attention.

O. Difficult labour.

U. Repulsed by birth.

Y. Positive self image or no change.

A P P E N D I X I

LIST OF VARIABLES TAKEN INTO ACCOUNT FROM INITIAL PRESENTATION

VARIABLES TAKEN INTO ACCOUNT FROM INITIAL PRESENTATION

1. Age
2. Ethnic group
3. Social economic class
4. Marital status
5. Parity
6. Education
7. Contraception usage
8. Religion
9. Family history of psychiatric care
10. Disrupted family background
11. Position in the family
12. Illegitimate, adopted or fostered child
13. Behaviour/academic difficulties at school
14. Relationship with parents
15. Parental preference
16. Socializing ability
17. Work performance
18. Previous sexual partner(s)
19. Previous illegitimate birth
20. Previous termination
21. Relationship with the reputed father
22. Previous psychiatric treatment
23. Previous suicide attempts
24. Poor image of self
25. Threats of suicide if refused termination
26. Threats of illegal abortion if refused termination
27. Intelligence
28. Length of pregnancy at presentation
29. Referred for psychiatric treatment
30. Parental involvement
31. Attended with reputed father
32. Support from male partner
33. Angry
34. Guilty

35. Hurt
36. Ambivalent
37. Acceptance
38. Hostile towards men
39. Denial of feelings
40. Hysterical behaviour

A P P E N D I X J

EXPLANATION OF THE STATISTICAL METHODS USED

EXPLANATION OF THE STATISTICAL METHODS USED

The data obtained in this study were both parametric and non-parametric. In order to study the distribution of the variables in the groups of patients advised, and the group of patients refused termination, the chi-square statistic was chosen, especially since assumptions did not have to be made about a normal distribution. Discriminant analyses on subsets of the 159 variables using a stepwise solution method were undertaken in an attempt to isolate those variables that influenced group allocation.

APPENDIX K

FURTHER RESULTS FROM INITIAL PRESENTATION DATA

TABLE 1

SIGNIFICANCE OF RELIGION

SAMPLE A

Religion	Term Group	Not Term Group	Total
Moslem	17	4	21
Jewish	3	8	11
Roman Catholic	15	10	25
Dutch Reformed	16	19	35
Anglican	23	20	43
Methodist	8	7	15
Other Christian church	19	14	33
Not known	6	8	14
TOTAL	107	90	197

X^2 = 11,515 (7df); NS

SIGNIFICANCE OF RELIGION

SAMPLE B

Religion	Term Group	Not Term Group	Total
Moslem	9	4	13
Jewish	3	8	11
Roman Catholic	13	10	23
Dutch Reformed	13	17	30
Anglican	20	19	39
Apostolic Faith Mission	0	1	1
Baptist	1	0	1
Congregational	0	4	4
Evangelical	2	1	3
Full Gospel Church	0	1	1
Lutheran	2	1	3
Methodist	7	7	14
Moravian	1	1	2

SAMPLE B (Cont.)

Religion	Term Group	Not Term Group	Total
New Apostolic	1	1	2
Pentecostal Protestant	1	0	1
Presbyterian	3	3	6
Old Apostolic	2	0	2
7th Day Adventist	1	0	1
Agnostic	2	3	5
Unknown	2	4	6
TOTAL	83	85	168

X^2 = 17,658 (19df); NS

TABLE 2

SIGNIFICANCE OF THE PATIENT'S POSITION IN THE FAMILY

SAMPLE A

Position in the Family	Term Group	Not Term Group	Total
Only child	5	5	10
Eldest child	22	17	39
Youngest child	29	30	59
Other position	51	38	89
TOTAL	107	90	197

X^2 = 1,098 (3df); NS

SIGNIFICANCE OF THE PATIENT'S POSITION IN THE FAMILY

SAMPLE B

Position in the Family	Term Group	Not Term Group	Total
Only child	5	5	10
Eldest child	17	14	31
Youngest child	24	30	54
Other position	37	36	73
TOTAL	83	85	168

$X^2 = 0{,}947$ (3df); NS

TABLE 3

SIGNIFICANCE OF GOOD RELATIONSHIP WITH OWN FATHER

SAMPLE A

	Present	Not Present	Total
Terminated	53	54	107
Not terminated	50	40	90
TOTAL	103	94	197

$X^2 = 0{,}710$ (1df); NS

SIGNIFICANCE OF GOOD RELATIONSHIP WITH OWN FATHER

SAMPLE B

	Present	Not Present	Total
Terminated	38	45	83
Not terminated	48	37	85
TOTAL	86	82	168

$X^2 = 1{,}515$ (1df); NS

TABLE 4

SIGNIFICANCE OF GOOD RELATIONSHIP WITH OWN MOTHER

SAMPLE A

	Present	Not Present	Total
Terminated	75	32	107
Not terminated	62	28	90
TOTAL	137	60	197

$X^2 = 0{,}033$ (1df); NS

SIGNIFICANCE OF GOOD RELATIONSHIP WITH OWN MOTHER

SAMPLE A

	Present	Not Present	Total
Terminated	57	26	83
Not terminated	60	25	85
TOTAL	117	51	168

X^2 = 0,010 (1df); NS

TABLE 5

SIGNIFICANCE OF PARENTAL PREFERENCE

SAMPLE A

Parental Preference	Term Gp	Not Term Gp	Total
Mother	36	19	55
Father	5	8	13
No preference	66	63	129
TOTAL	107	90	197

X^2 = 4,583 (2df); NS

SIGNIFICANCE OF PARENTAL PREFERENCE

SAMPLE A

Parental Preference	Term Gp	Not Term Gp	Total
Mother	26	18	44
Father	3	8	11
No preference	54	59	113
TOTAL	83	85	168

X^2 = 3,925 (2df); NS

TABLE 6

SIGNIFICANCE OF ATTENDED WITH REPUTED FATHER

SAMPLE A

	Present	Not Present	Total
Terminated	10	97	107
Not terminated	10	80	90
TOTAL	20	177	197

X^2 = 0,167 (1df); NS

SIGNIFICANCE OF ATTENDED WITH REPUTED FATHER

SAMPLE B

	Present	Not Present	Total
Terminated	10	73	83
Not terminated	9	76	85
TOTAL	19	149	168

X^2 = 0,003 (1df); NS

TABLE 7

SAMPLE A

Attitudes	Term Gp (107)	Not Term Gp (90)	Total (197)	X^2	df	P
Hostile towards men	5	6	11	0,368	1	NS
Hysterical behaviour	9	10	19	0,408	1	NS

SAMPLE B

Attitudes	Term Gp (83)	Not Term Gp (85)	Total (168)	X^2	df	P
Hostile towards men	5	4	9	0,001	1	NS
Hysterical behaviour	8	9	17	0,002	1	NS

APPENDIX L

1. RAW SCORES FOR EMOTIONAL RESPONSES.
2. FURTHER RESULTS OF TOTAL SAMPLE OF EMOTIONAL REACTIONS (1-3).
3. FURTHER RESULTS OF MODIFIED SAMPLE OF EMOTIONAL REACTIONS (4-5).

IMMEDIATE REACTION TO ABORTION OF THOSE TERMINATED

Total 77

	1	2	3	4	5
Depression	23	14	15	7	18
Relief	8	6	7	13	43
Regret	47	8	8	10	4
Embarrassment	34	14	8	9	12
Guilt	33	14	7	8	15
Anxiety	26	18	17	8	8
Shame	43	9	8	6	11
Fear of disapproval	32	14	5	13	13
Anger	50	5	9	4	9
Happiness	16	14	9	16	22
Doubt	38	14	11	6	8
Disappointment in self	25	14	10	6	22
Denial of feelings	30	11	10	13	13

LONG-TERM REACTION TO ABORTION
OF THOSE TERMINATED

Total 77

	1	2	3	4	5
Depression	52	14	5	3	3
Relief	8	3	6	11	49
Regret	54	9	7	2	5
Embarrassment	54	13	2	2	6
Guilt	41	13	8	5	10
Anxiety	43	12	12	3	7
Shame	50	8	9	3	7
Fear of disapproval	46	6	8	6	11
Anger	61	5	2	4	5
Happiness	16	6	10	15	30
Doubt	54	11	5	1	6
Disappointment in self	32	13	9	10	13
Denial of feelings	36	11	6	13	11

IMMEDIATE REACTION AFTER REFUSAL OF ABORTION

Total 28

	1	2	3	4	5
Depression	6	8	3	4	7
Relief	7	9	4	0	8
Regret	9	8	2	5	4
Embarrassment	14	4	3	1	6
Guilt	9	3	4	6	6
Anxiety	4	4	5	5	10
Shame	13	2	2	2	9
Fear of disapproval	8	4	2	2	12
Anger	14	3	5	3	3
Happiness	8	5	6	3	6
Doubt	7	3	7	5	6
Disappointment in Self	10	5	1	3	9
Denial of feelings	13	2	7	3	3

LONG-TERM REACTION TO REFUSAL OF ABORTION

Total 28

	1	2	3	4	5
Depression	20	3	2	0	3
Relief	4	10	1	2	11
Regret	16	6	4	1	1
Embarrassment	17	4	2	4	1
Guilt	14	3	4	3	4
Anxiety	12	5	3	1	7
Shame	15	4	1	5	3
Fear of disapproval	13	4	3	1	7
Anger	20	2	3	1	2
Happiness	7	1	3	4	13
Doubt	12	5	7	2	2
Disappointment in self	15	3	1	3	6
Denial of feelings	15	3	2	4	4

1. LONG-TERM REACTION OF ABORTION VERSUS LONG-TERM REACTION OF REFUSAL FOR ABORTION

Depression

	1	2	3	4	5
Terminated	52	14	5	3	3
Not Terminated	20	3	2	0	3

X^2 = 3,527 (4df); NS

Regret

	1	2	3	4	5
Terminated	54	9	7	2	5
Not Terminated	16	6	4	1	1

X^2 = 2,787 (4df); NS

Embarrassment

	1	2	3	4	5
Terminated	54	13	2	2	6
Not Terminated	17	4	2	4	1

X^2 = 6,926 (4df); NS

Guilt

	1	2	3	4	5
Terminated	41	13	8	5	10
Not Terminated	14	3	4	3	4

X^2 = 1,332 (4df); NS

Anxiety

	1	2	3	4	5
Terminated	43	12	12	3	7
Not Terminated	12	5	3	1	7

X^2 = 4,97 (4df); NS

Shame

	1	2	3	4	5
Terminated	50	8	9	3	7
Not Terminated	15	4	1	5	3

X^2 = 7,431 (4df); NS

Fear of Disapproval

	1	2	3	4	5
Terminated	46	6	8	6	11
Not Terminated	13	4	3	1	7

X^2 = 3,482 (4df); NS

Anger

	1	2	3	4	5
Terminated	61	5	2	4	5
Not Terminated	20	2	3	1	2

X^2 = 3,142 (4df); NS

Happiness

	1	2	3	4	5
Terminated	16	6	10	15	30
Not Terminated	7	1	3	4	13

X^2 = 1,387 (4df); NS

Disappointment in Self

	1	2	3	4	5
Terminated	32	13	9	10	13
Not Terminated	15	3	1	3	6

X^2 = 2,915 (4df); NS

Denial of Feelings

	1	2	3	4	5
Terminated	36	11	6	13	11
Not Terminated	13	3	2	4	4

X^2 = 0,193 (4df); NS

2. IMMEDIATE REACTION VERSUS LONG-TERM REACTION OF THOSE TERMINATED

Relief

	1	2	3	4	5
Immediate Reaction	8	6	7	13	43
Long-term Reaction	8	3	6	11	44

X^2 = 1,088 (4df); NS

Regret

	1	2	3	4	5
Immediate Reaction	47	8	8	10	4
Long-term Reaction	54	9	7	2	5

X^2 = 6,055 (4df); NS

Guilt

	1	2	3	4	5
Immediate Reaction	33	14	7	8	15
Long-term Reaction	41	13	8	5	10

X^2 = 2,66 (4df); NS

Anxiety

	1	2	3	4	5
Immediate Reaction	26	18	17	8	8
Long-term Reaction	43	12	12	3	7

X^2 = 8,589 (4df); NS

Shame

	1	2	3	4	5
Immediate Reaction	43	9	8	6	11
Long-term Reaction	50	8	9	3	7

X^2 = 2,533 (4df); NS

Fear of Disapproval

	1	2	3	4	5
Immediate Reaction	32	14	5	13	13
Long-term Reaction	46	6	8	6	11

X^2 = 9,15 (4df); NS

Anger

	1	2	3	4	5
Immediate Reaction	50	5	9	4	9
Long-term Reaction	61	5	2	4	5

X^2 = 6,687 (4df); NS

Happiness

	1	2	3	4	5
Immediate Reaction	16	14	9	16	22
Long-term Reaction	16	6	10	15	30

X^2 = 4,515 (4df); NS

Doubt

	1	2	3	4	5
Immediate Reaction	38	14	11	6	8
Long-term Reaction	54	11	5	1	6

X^2 = 9,249 (4df); NS

Disappointment in Self

	1	2	3	4	5
Immediate Reaction	25	14	10	6	22
Long-term Reaction	32	13	9	10	13

X^2 = 4,263 (4df); NS

Denial of Feelings

	1	2	3	4	5
Immediate Reaction	30	11	10	13	13
Long-term Reaction	36	11	6	13	11

X^2 = 1,712 (4df); NS

3. IMMEDIATE VERSUS LONG-TERM REACTION OF THOSE NOT TERMINATED

Relief

	1	2	3	4	5
Immediate Reaction	7	9	4	0	8
Long-term Reaction	4	10	1	2	11

X^2 = 5,144 (4df); NS

Regret

	1	2	3	4	5
Immediate Reaction	9	8	2	5	4
Long-term Reaction	16	6	4	1	1

X^2 = 7,379 (4df); NS

Embarrassment

	1	2	3	4	5
Immediate Reaction	14	4	3	1	6
Long-term Reaction	17	4	2	4	1

X^2 = 5,861 (4df); NS

Guilt

	1	2	3	4	5
Immediate Reaction	9	3	4	6	6
Long-term Reaction	14	3	4	3	4

X^2 = 2,486 (4df); NS

Anxiety

	1	2	3	4	5
Immediate Reaction	4	4	5	5	10
Long-term Reaction	12	5	3	1	7

X^2 = 7,807 (4df); NS

Shame

	1	2	3	4	5
Immediate Reaction	13	2	2	2	9
Long-term Reaction	15	4	1	5	3

X^2 = 5,428 (4df); NS

Fear of Disapproval

	1	2	3	4	5
Immediate Reaction	8	4	2	2	12
Long-term Reaction	13	4	3	1	7

X^2 = 3,039 (4df); NS

Anger

	1	2	3	4	5
Immediate Reaction	14	3	5	3	3
Long-term Reaction	20	2	3	1	2

X^2 = 2,958 (4df); NS

Happiness

	1	2	3	4	5
Immediate Reaction	8	5	6	3	6
Long-term Reaction	7	1	3	4	13

X^2 = 6,455 (4df); NS

Doubt

	1	2	3	4	5
Immediate Reaction	7	3	7	5	6
Long-term Reaction	12	5	7	2	2

X^2 = 5,101 (4df); NS

Disappointment in Self

	1	2	3	4	5
Immediate Reaction	10	5	1	3	9
Long-term Reaction	15	3	1	3	6

X^2 = 2,099 (4df); NS

Denial of Feelings

	1	2	3	4	5
Immediate Reaction	13	2	7	3	3
Long-term Reaction	15	3	2	4	4

X^2 = 3,406 (4df); NS

4. IMMEDIATE REACTION TO DECISION MADE GIVEN RETROSPECTIVELY

Depression

	1	2	3	4	5	Total
Not Recommended	7	10	4	6	12	39
Recommended	19	11	13	5	10	58
TOTAL	26	21	17	11	22	97

X^2 = 7,177 (4df); NS

Embarrassment

	1	2	3	4	5	Total
Not Recommended	21	5	5	1	7	39
Recommended	25	13	6	6	8	58
TOTAL	46	18	11	7	15	97

X^2 = 4,066 (4df); NS

Shame

	1	2	3	4	5	Total
Not Recommended	20	3	2	5	9	39
Recommended	34	7	7	2	8	58
TOTAL	54	10	9	7	17	97

X^2 = 5,854 (4df); NS

Fear of Disapproval

	1	2	3	4	5	Total
Not Recommended	13	6	2	6	12	39
Recommended	26	12	3	8	9	58
TOTAL	39	18	5	14	21	97

X^2 = 3,666 (4df); NS

Anger

	1	2	3	4	5	Total
Not Recommended	23	3	7	4	2	39
Recommended	37	5	6	2	8	58
TOTAL	60	8	13	6	10	97

X^2 = 4,563 (4df); NS

Doubt

	1	2	3	4	5	Total
Not Recommended	11	6	8	8	6	39
Recommended	29	11	9	3	6	58
TOTAL	40	17	17	11	12	97

X^2 = 8,506 (4df); NS

Disappointment in Self

	1	2	3	4	5	Total
Not Recommended	11	6	5	4	13	39
Recommended	21	13	6	5	13	58
TOTAL	32	19	11	9	26	97

X^2 = 2,271 (4df); NS

Denial of Feelings

	1	2	3	4	5	Total
Not Récommended	15	4	8	5	7	39
Recommended	27	9	9	5	8	58
TOTAL	42	13	17	10	15	97

X^2 = 1,825 (4df); NS

5. LONG-TERM REACTION TO THE DECISION MADE GIVEN AT FOLLOW-UP

Depression

	1	2	3	4	5	Total
Not Recommended	23	9	3	1	3	39
Recommended	43	8	4	1	2	58
TOTAL	66	17	7	2	5	97

x^2 = 2,849 (4df); NS

Embarrassment

	1	2	3	4	5	Total
Not Recommended	26	6	3	1	3	39
Recommended	49	9	1	1	6	58
TOTAL	67	15	4	2	9	97

x^2 = 2,325 (4df); NS

Guilt

	1	2	3	4	5	Total
Not Recommended	17	6	7	4	5	39
Recommended	34	9	4	4	7	58
TOTAL	51	15	11	8	12	97

x^2 = 3,844 (4df); NS

Anxiety

	1	2	3	4	5	Total
Not Recommended	18	7	7	1	6	39
Recommended	35	7	8	3	5	59
TOTAL	53	14	15	4	11	97

x^2 = 3,004 (4df); NS

Shame

	1	2	3	4	5	Total
Not Recommended	22	6	4	5	2	39
Recommended	41	3	6	3	5	58
TOTAL	63	9	10	8	7	97

X^2 = 5,401 (4df); NS

Fear of Disapproval

	1	2	3	4	5	Total
Not Recommended	17	7	5	3	7	39
Recommended	40	3	5	3	7	58
TOTAL	57	10	10	6	14	97

X^2 = 7,444 (4df); NS

Anger

	1	2	3	4	5	Total
Not Recommended	29	4	3	1	2	39
Recommended	46	3	1	3	5	58
TOTAL	75	7	4	4	7	97

X^2 = 3,702 (4df); NS

Happiness

	1	2	3	4	5	Total
Not Recommended	13	1	5	7	13	39
Recommended	10	6	8	8	26	58
TOTAL	23	7	13	15	39	97

X^2 = 5,546 (4df); NS

Disappointment in Self

	1	2	3	4	5	Total
Not Recommended	15	4	7	4	9	39
Recommended	28	11	3	8	8	58
TOTAL	43	15	10	12	17	97

X^2 = 6,725 (4df); NS

Denial of Feelings

	1	2	3	4	5	Total
Not Recommended	19	5	4	6	5	39
Recommended	31	7	4	6	10	58
TOTAL	50	12	8	12	15	

X^2 = 1,204 (4df); NS

APPENDIX M

STERILIZATION

STERILIZATION

The Lane Commission defines sterilization as "any operation which renders the individual incapable of producing a child. In the female this is usually accomplished by obstructing the Fallopian tubes, though it may be achieved by other operative procedures, e.g. vasectomy in male sterilization" (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.271). It is, therefore, a contraceptive measure with usually irreversible consequences, although great advances have been made in the United Kingdom with regard to the latter.

Originally used for strict medical and eugenic indications, tubal sterilization is rapidly becoming simply another method of contraception requested by a larger number of patients each year (Edwards and Hakanson, 1973). With this increased demand, the advantages of the operation must be weighed against possible disadvantages, such as operative risks and post-operative morbidity. The irreversibility of the procedure raises doubts as to its advisability in young women because of the risk of early widowhood and/or remarriage. More important is the risk that some women may later regret the operation and suffer morbidity directly attributable to it (Enoch and Jones, 1975).

In any discussion on sterilization, consideration must be given to the various types - punitive, eugenic, therapeutic, contraceptive and compulsory sterilization.

In the past sterilization has been judicially imposed as a penalty for crime with a retributive and possibly deterrent effect, to protect society against a repetition of the offence, e.g. statutes at one time in Washington and Nevada called for this operation on a person convicted of rape (Gampell, 1964). Today penal sterilization has fewer advocates. It does not diminish the sexual impulse and does nothing for the sexually promiscuous person. Statutes governing penal sterilization in the United States have been attacked on the grounds that

they violated the constitutional prohibition against cruel and unusual punishment. The Washington statute was repealed while that of Nevada was struck off as unconstitutional.

Eugenic sterilization involves the issue of the reproduction of those individuals who are known to suffer from a serious hereditary mental or physical disease. Ethical questions arise, e.g. should a young woman, due to get married, one of whose parents is known to have suffered from Huntingdon's Chorea, be sterilized since she herself had a 50% chance of having the disease? If not sterilized, could she be relied upon to use appropriate contraceptive measures? Is it reasonable for her to have a child who will even if the mother has not yet displayed signs, have a 25% chance of inheriting it? Eugenic sterilization, then, is concerned with sterilization as a means of improving the genetic quality of the race.

Therapeutic sterilization includes situations in which the operation is necessary either to remove a diseased organ in the woman, or as a means of removing the risks inherent in the patient's bearing of a child, e.g. the increased risks of repeated Caesarean deliveries. Therapeutic sterilization is usually considered in the latter case when other contraceptive measures have failed in the past.

Contraceptive sterilization concerns those in whom the operation is used solely as a means of preventing further births. Compulsory sterilization has been used in the past, i.e. penal sterilization. A second form of forced sterilization still practised in some hospitals in the United States, United Kingdom, Canada and elsewhere, is that associated with abortion. When the law places the abortion decision in the hands of physicians and hospitals, they sometimes agree to perform an abortion in certain situations only if the woman also accepts sterilization (Sarvis and Rodman, 1973).

Women seeking a sterilization operation may be divided into two categories. Firstly, there are those who are aware of both the results of coitus and of sterilization.

These women are invariably married and decide in consultation with their spouses that the family is now complete. In some instances, the marriage itself may be under strain due to the dread of a further pregnancy, and lack of confidence in other contraceptive devices. The second category consists of those retarded women who do not understand the meaning or result of coitus, who are open to sexual exploitation and who would not be capable of guarding themselves from such advances. Women in the first category are handled in the same manner as in any other medical procedure, although the husband's consent is usually required. However, the law in many countries protects women or girls in the second category specifying, for example, that a psychiatrist be involved in the assessment for the operation.

Legal measures setting out the grounds on which an abortion may be procured, invariably include those on which a woman may be sterilized, e.g. in Sweden according to the Sterilization Act of 1941, a woman may be sterilized on eugenic, social, medical and medico-social indications (Ekblad, 1955). However, in the United Kingdom there are no legal criteria which have to be satisfied before it can be performed and it is left to the discretion of the doctor. This situation led to the setting out of the following guidelines by the Lane Commission (Report of the Committee on the Working of the Abortion Act, Vol. I, 1974, p.168). They recommended that performance of sterilization should be:

1. "After careful counselling of the woman and of her husband, or other partner in a stable union, and counselling should also be available, if desired, after the operation when doubts and regrets may be felt;

2. not carried out except in an emergency until there has been due time for reflection;

3. mainly confined to cases where there is medical or genetic necessity to avoid future pregnancy,

or where both parties are sure that they do not want more children;

4. never as a condition of terminating an existing pregnancy, or as a result of any other pressure;

5. after consideration of whether sterilization of the woman or vasectomy for the man, is the more appropriate in their circumstances."

The passing of the Abortion and Sterilization Act 2/75 in South Africa marked the first occasion on which legal grounds for a sterilization were defined. Prior to this there had been no legal coverage for a psychiatrist recommending the sterilization of a woman on psychiatric grounds. It was considered a medical procedure in which the needs and capabilities of each individual were assessed. If sterilization was considered appropriate, the psychiatrist would notify the medical superintendent of the hospital concerned of his decision and reasons for it. Consent was required from the legal guardian or husband, if the woman was married.

The Abortion and Sterilization Act 2/75 lays down the following conditions under which sterilization of a person unable to give consent might be performed (Abortion and Sterilization Act 2/75, Paragraph 4, Subsection 1):

(a) Two medical practitioners, one of whom shall be a psychiatrist, have certified in writing that the person concerned is capable of procreating children, and

(i) is suffering from a hereditary condition of such a nature that if he or she were to procreate a child, such a child would suffer from a physical or mental defect of such a nature that it would be seriously handicapped; or

(ii) due to a permanent mental handicap or defect is unable to comprehend the consequential implications of, or bear the

parental responsibility of coitus;

(b) the person who may in law consent to an operation beneficial to that person has granted written consent to the sterilization and

(c) the Minister has granted written authority for the sterilization.

The Act covers those persons capable of giving consent themselves by stating in Paragraph 4, Subsection 3 that "the provisions .... shall not be construed as affecting the position in law of any person capable of consent or competent to consent to an operation on himself."

The Act also lays down that such operations should be performed at a State controlled hospital or any other institution so designated by the Minister, and that the patient should be assessed by a psychiatrist employed by the State. In the case of severely mentally retarded women, conception is considered to have taken place in contravention of section 15 of the Immorality Act 23/57 and as such has to be reported to the local magistrate (Abortion and Sterilization Act 2/75, Paragraph 6, Subsection 4).

A number of studies have been conducted on sterilization performed on psychiatric grounds. Ekblad (1955) followed up 81 women from two to three years after the operation. He found that 86% (70 women) had been satisfied with the operation since its performance, four women were dissatisfied and seven had not quite been satisfied. Of those women who were directly dissatisfied with the sterilization or who had regretted the operation, all had been obliged to consent to the procedure in order to have a legal abortion which they desired, or had been persuaded to submit to sterilization.

Schwyhart and Kutner (1973) in the United States reviewed 22 studies conducted between 1949 and 1969 of women who had received tubal ligations primarily for contraceptive reasons. He found that results showed a higher percentage of women

expressed regret over sterilization in studies in which (1) women had had fewer than four children and (2) therapeutic abortion was performed concomitantly with sterilization. They concluded that low parity and concomitant abortion were associated with dissatisfaction with sterilization.

Sim et al (1973) in the United Kingdom sought out the reaction of 151 women who had been sterilized for social or gynaecological reasons, some one and three years after the operation. 146 were completely satisfied with the results of the procedure, both on their general health and on the sexual relationship in the marriage. They concluded that adverse psychiatric sequelae of sterilization could be kept to a minimum by the careful selection of patients, using the following criteria: the women should be over the age of 30 years, should have had two or more children and the operation should not be performed at childbirth, in the neonatal period or during a post-abortive depression.

Khorana and Vyas (1975) in the United Kingdom assessed 374 women and their husbands at an interval ranging from three months to two years after sterilization. He found that 83% of the subjects complained of various symptoms of presumed psychological origin, 65% reported decreased libido and 29% had not resumed sexual intercourse. Paradoxically, satisfaction with the operation was expressed by 92% of the women. Compared with other studies, the prevalence of adverse changes in psychological and sexual functioning appeared to be very high.

Enoch and Jones (1975) in the United Kingdom, followed up 98 women who had been sterilized after a three year interval. They found that 76% of the women were satisfied with the operation, 21% occasionally felt regret and 3% constantly felt regret. Among the group expressing regret were found incidences of marital (6%) and sexual (22%) deterioration and psychological morbidity. They concluded that an unstable personality and a past history of psychiatric illness were

useful predictions of an unsatisfactory outcome. Age was not found to be an important factor in any of the results. There was, however, greater regret found among women who had had fewer than two children.

REPORT ON THE PRESENT STUDY

The Clinical Service Offered to Patients

Over the period 1/2/74 - 31/5/75, 42 women were referred for a psychiatric opinion on sterilization to the Department of Psychiatry, Groote Schuur Hospital. This clinic also handled those patients referred for assessment for therapeutic abortion on psychiatric grounds. Of the 42 patients referred, 18 were also referred for therapeutic abortion and were thus assessed by the same staff.

All cases were referred directly from the Department of Obstetrics and Gynaecology to a psychiatric social worker. A detailed psychosocial history was taken of the patient. Where the patient was mentally retarded, a close relative was required in order to obtain this information. Details of the operation were explained to the patient or relative. The reason why sterilization as opposed to other contraceptive measures was being requested was also explored. Intelligence testing, using appropriate scales, was also carried out in the Department on those patients who were mentally retarded. After all data had been collected, the patient was presented to the consultant psychiatrist attached to the service. If sterilization was recommended, the patient would be referred back to the Department of Obstetrics and Gynaecology. An attempt was made to follow up all patients referred whether sterilization was recommended or not and if considered appropriate, patients would be put in contact with an outside agency for ongoing supervision and support.

The aims of the service may be summarized as follows:

1. To maintain a level of consistent opinion by using the same staff for assessment.

2. To provide a counselling service as rendered by the psychiatric social worker during assessment and at follow-up.
3. In the case of the mentally retarded patients, to ensure that referral to an appropriate outside agency for long-term personal and family support was made.

Collection of Data

Information was collected initially using the psychiatric social worker's extensive intake history, either directly from the patient or from the relatives concerned. In the case of mentally retarded patients, additional data was gathered from the intelligence tests performed by a clinical psychologist. If the patient was known to another agency, this too was approached for further data. For the purpose of this study, all data was collated on punch cards, additional data being added at the initial and long-term follow-up.

RESULTS

(a) Description of the Patients Referred

A total of 42 patients were referred in the period 1/2/74 - 31/5/75; 18 of these were also referred for an opinion on therapeutic abortion.

Thirty-seven of the patients were Coloured or Indian, four were White and one African.

Five patients were under 16 years of age, 14 were between the ages of 16 and 20 years, nine between the ages of 21 and 29 years, and 14 were over the age of 30.

Examining the social economic class distribution showed that 10 patients were classified as in Class III and IV and 32 patients in Class V and VI. No patients came from Classes I and II.

Thirty of the patients were single, 10 married and two separated or divorced. Eighteen patients were nulliparous, 18 had less than six children, while six had more than six children.

Twenty of the patients referred had had previous psychiatric treatment, either on an outpatient or inpatient basis.

Twelve of the total number of patients referred expressed ambivalence with regard to the sterilization operation.

Data was also gathered on the intelligence level and educational standard of those patients referred. Twenty-seven of the 42 patients referred were psychologically tested using the Old South African Individual Scale (Fick, 1939). Eighteen of these patients had an I.Q. score of below 50, seven between 50 and 60 and two between 60 and 70. The remaining 15 patients were not tested as they were considered to be of 'average' intelligence. Twelve of the total number of patients referred had had no education at all, 22 had only attended a primary school, and eight had been to a high school.

Fifteen patients attended the follow-up interview at one to two months after the operation. All had been recommended for sterilization and in all instances either the patient, or a relative in the case of mental defectives, expressed satisfaction. Originally 16 of the 42 patients had been referred to outside community agencies for long-term support. Eleven of these patients did not attend the initial study follow-up. A later follow-up of those patients who were sterilized, with or without termination of pregnancy, was conducted at 12 - 18 months after the operation. A total of 21 patients responded; 20 of these had been granted sterilization and one refused. All 21 expressed satisfaction with the decision made. An additional three patients from the termination group reported on in the previous study, were also sterilized.

(b) Comparison of those Patients Referred only for Sterilization with those Referred for Sterilization and Termination

Over the period 1/2/74 - 31/5/75 a total of 24 patients were referred for a psychiatric opinion on sterilization, while 18 were referred both for a psychiatric opinion on sterilization and termination.

Table I shows a comparison of the age group of the two types of referral.

TABLE I

Age	Sterilization	Sterilization and Termination
Under 16 years	4	1
16 - 20 years	13	1
21 - 29 years	5	4
30 years and over	2	12
TOTAL	24	18

Thus, the majority of referrals for sterilization (54%) came from the 16 - 20 year old age group, while the majority of the referrals for both sterilization and termination (67%) came from the 30 years and over category.

Examining the ethnic group distribution, three White patients presented for an opinion for sterilization and one White patient presented for an opinion for sterilization and termination; no African patients were referred for sterilization alone and only one was referred for sterilization and termination.

Table II shows the social economic class distribution of the two types of referrals.

TABLE II

Social Economic Class	Sterilization	Sterilization & Termination
Social Class I & II	0	0
Social Class III & IV	4	6
Social Class V & VI	20	12
TOTAL	24	18

In both types of referrals, the majority of the patients came from the lower income group.

Eleven of the patients presenting for an opinion on sterilization were nulliparous and the remaining 13 had less than six children each and six had six or more children each.

Twenty-one of the patients presenting for an opinion on sterilization only were single and three were married. Of the 18 patients presenting for an opinion on sterilization and termination, nine were single, seven married and two divorced.

The educational level of both groups of referrals was also examined. Of those who presented for sterilization only, 11 had had no education, 11 had attended a primary school and two had attended a high school. By comparison, of those patients referred for an opinion on sterilization and termination, one had had no education, 11 had attended a primary school and six had attended a high school.

Not all patients could express their feeling reactions to the situation; of those who could, nine presenting for an opinion on sterilization appeared ambivalent about the operation as opposed to three patients who presented for an opinion on sterilization and termination.

Data on the number of weeks pregnant, the quality of the relationship and the use of contraception was only gathered on those 18 patients presenting for an opinion on both sterilization and termination. Nine of the patients presented before the 12th week of gestation, six between the

12th and 19th week and three in or after the 20th week of pregnancy. One patient stated that the pregnancy was the result of rape, five admitted that it was the result of a promiscuous affair, and 12 the result of a long-standing relationship. Eight patients had never used any form of contraception, four reported failure of contraception and the remaining six patients were either mental defectives or had been raped.

(c) Recommendations

Of the 42 patients referred over the period 1/2/74 - 31/5/75, 24 were for a psychiatric opinion on sterilization alone. Of these, 15 were recommended for sterilization, nine not recommended. A total of 18 cases were received for psychiatric assessment on sterilization and termination. Of these, 17 patients were recommended for both and one patient was not recommended for either.

(d) Previous Psychiatric Treatment in Relation to Recommendation

Of the nine non-pregnant patients who were not recommended for sterilization, five patients had received psychiatric treatment, viz. three of these were mental defectives with I.Q. scores of 36, 45 and 67 and under the supervision of a local mental health agency. One patient was a certified schizophrenic and another had received outpatient treatment for an anxiety state. Two patients were under the age of 16 years, two between 16 and 20 years, and one between 21 and 29 years. Four of these patients were Coloured and one was White. Two had received no education, two had attended primary school and one high school. Two came from social economic class III and IV, and three from social economic class V and VI. Four were single and one was married. Three of these patients were considered to be ambivalent about sterilization.

Of the 15 non-pregnant patients who were recommended for the sterilization, nine had received previous psychiatric treatment. Seven of these patients were mentally retarded

and under a local mental health society. The other two patients attended a local mental hospital, both were psychotic with one also being retarded and the other a deteriorated epileptic. I.Q. scores on these patients ranged from 20 - 55. One patient was under the age of 16 years, four between 16 and 20 years, two between the ages of 21 and 28 years, and two over the age of 30 years. All nine patients were Coloured. Two came from social economic class III and IV and seven from social economic class V and VI. Six patients had had no formal education, while three had attended primary school. All nine of the patients were single. One of these patients was considered to be ambivalent about the operation.

Only one patient was refused both the sterilization and termination of pregnancy operation and she had received no previous psychiatric treatment. Of the remaining 17 patients referred for both procedures, six had received psychiatric treatment. Three of these patients were mentally retarded, two being under the care of a community based mental health society, and one having previously been in a home for the mentally retarded. Two of these six patients had had admissions to a local mental hospital, one diagnosed as a psychotic depression and the other as epileptic and psychotic. A further patient had previously been treated for hysterical neurosis in a psychiatric outpatient department. The I.Q. scores of the mentally retarded patients were 40, 43 and 54. One patient had received no education at all, four had attended a primary school and one a high school. One patient fell in the category 16 - 20 years, two in the category 21 - 29 years and 3 in the category of 30 years and above. Five of the patients were Coloured and one African. All six came from the social economic class V and VI. Five were single and one married. Four were nulliparous, one had less than six children and one had more than six children. Three of these patients presented prior to the 12th week of pregnancy and three between the 12th and 19th week. In three of the patients conception had been the result of a promiscuous

relationship, while in the remaining three it had resulted from a long-standing relationship. Three had never bothered about contraception and three were mentally retarded.

DISCUSSION OF THE RESULTS

In this study requests and/or decisions about sterilization were closely linked with social class and psychiatric status. Thirty-two patients came from social economic class V and VI, the remaining 10 from social class III and IV.

All four of the patients not recommended for the sterilization procedure were mental defectives and I.Q. levels of 35, 45, 48 and 54. Two were White and two Coloured. Three were single and nulliparous with one being married with one child. All were under the age of 21 years.

Of the six patients recommended for sterilization who had not received previous psychiatric treatment, five were found to be mental defectives with an I.Q. range of 34 - 55. All were Coloured between the ages of 16 and 30 years and came from social class V and VI.

Three of the patients recommended for both procedures, but who had not received previous psychiatric treatment, were found to be mentally defective with I.Q. scores of 46, 52 and 65. All were Coloured and from social class V.

TABLE III

TOTAL DISTRIBUTION OF I.Q. SCORES

I.Q. Score	Recommended for one or both Procedures	Not recommended for either Procedure	Total
IQ less than 60	18	6	24
IQ 60 but less than 70	2	1	3
TOTAL	20	7	27

TABLE IV

DISTRIBUTION OF I.Q. SCORES FOR STERILIZATION PROCEDURE ALONE

I.Q. Score	Sterilization Recommended	Sterilization not Recommended	Total
IQ less than 60	13	6	19
IQ 60 but less than 70	1	1	2
TOTAL	14	7	21

TABLE V

DISTRIBUTION OF I.Q. SCORES FOR BOTH PROCEDURES

I.Q. Score	Both Procedures Recommended	Both Procedures not Recommended	Total
IQ less than 60	5	0	5
IQ 60 but less than 70	1	0	1
TOTAL	6	0	6

Twenty of the patients had previously been classed as psychiatric patients - twelve being mentally retarded and being supervised in the community by a mental health society, another six having been inpatients at mental hospitals when psychotic and a further two patients having been treated as outpatients.

Although only twelve were patients previously identified as retarded, mental retardation was one of the chief indications for referral and assessment, and it had only become an issue once pregnancy had occurred. Twenty-seven of the 42 patients seen had an I.Q. of under 70. Of these, 20 patients were recommended for sterilization, including six for sterilization and therapeutic abortion. The remaining seven patients were not recommended on account of their own reluctance in the light of sufficient understanding of the procedure. Of the entire group of 42, 12 patients were considered to be ambivalent. Of these, eight were not recommended for sterilization

due to their attitude. Sterilization should never be forced on the patient and should never be made a condition for therapeutic abortion.

Twelve patients were either married or divorced and on inquiry, they considered their families to be complete. Nine of these were recommended for sterilization, eight of whom were recommended for therapeutic abortion as well. Eight of these 12 patients had never used any form of contraception.

It should be noted that psychiatric involvement in the sterilization decision is confined to those patients considered mentally defective and in those cases where there is a possibility of a congenital abnormality. Of the 24 patients referred for an opinion on sterilization only, 21 were found to have an I.Q. of under 70. Thus, only three women were not assessed according to their I.Q. levels, but due to ambivalence over the procedure and their gynaecologist wanting to obtain a second opinion. The sample of 42 patients presented here is weighted by the 18 patients who were primarily referred for assessment for therapeutic abortion but where sterilization was also advised, either on the request of the woman or on account of limited intellectual resources.

While 30 of the 42 patients were single, only 18 were nulliparous. The youngest age group recommended for sterilization was between 16 and 18 years, and chiefly involved the severely mentally retarded females. The largest age group requesting sterilization was that of the over 30 years category, numbering 14 cases, of which 13 were recommended. These were mainly the married women discussed previously. Many of the women had had little or no education. Twelve had had no education, 22 had attended primary school and only eight had entered high school. At follow-up, 16 patients were referred to outside agencies for ongoing support. All 21 patients seen at follow-up 12 - 18 months after the operation for sterilization and therapeutic abortion, expressed satisfaction.

CONCLUSIONS

From the above survey, the following may be concluded:

1. Women in whom sterilization is considered on psychiatric grounds in this area may be divided into two categories:

   (a) Those who are pregnant and yet feel that their families are complete and do not wish to have the child, or to use, or are unable to use other contraceptive measures. These patients are generally seen as routine gynaecological patients. Only when there is distress over the pregnancy, with or without a previous psychiatric history, is the opinion of a specialist psychiatrist sought and sterilization might be advised.

   (b) Mentally retarded females who are open to sexual exploitation and do not fully understand the outcome of coitus. In terms of the Abortion and Sterilization Act 2/75, legal measures for the sterilization of such cases are laid down in order to protect the best interests of such females.

2. In either of the above cases, careful counselling of the patient, husband or legal guardian is required and a full explanation of the procedure should be given if the woman has the intelligence to grasp the situation, to avoid regret or depression post-operatively.

3. According to the law, the psychiatrist only has a mandate to assess women for sterilization where there is a possibility of a congenital mental abnormality or in cases where the woman is moderately or severely mentally retarded. However, the majority of patients actively seeking this type of contraception appear to come from the lower social class women with little education, and help is mainly sought at the time of an unwanted pregnancy. Sterilization is requested even when other means of contraception may be known to the patient. In

the Western Cape, this is particularly relevant with regard to the Cape Coloured group.

4. It is of great importance to treat each case individually and to note any ambivalence on the part of the patient. Sterilization should ideally be considered separately from other issues, e.g. an unwanted pregnancy. The problem is that at a time like this, women seek and demand help, especially women from social class V and VI, of below normal intelligence and with little education. The attitudes and feelings of the mentally retarded patient should be taken as seriously as those of other patients requesting the same operation.

5. Follow-up counselling is of value to both groups of patients. In the first category, they may provide the patient with the opportunity to work through any feelings of regret, and in the second, ensure that adequate long-term supervision is made available by referral to the appropriate outside agency.

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