The Psychiatrist and Abortion

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TRADITIONAL ATTITUDES TOWARD ABORTION

In the past, when the obstetrician, with appropriate consultation, determined that a pregnancy threatened the mother's life and/or health, interruption of the pregnancy was medically and legally sanctioned. Reasons for termination of pregnancy included the threat to the mother's psychological health as well as to her physical well-being — that is, if the pregnancy were sufficiently stressful to the mother that she was reacting with an actual or impending psychotic break, interruption of pregnancy was sanctioned.

However, the psychiatric criteria for a therapeutic abortion have never been as clear-cut or as easily defined as have the medical criteria. Whereas serious infections, toxemias, and cardiac complications are easily and objectively identified, psychiatric disorders, even serious ones, may demonstrate little objective evidence, but may instead present themselves primarily as a subjective experience. Consequently, interruption of pregnancy for psychiatric reasons has depended on the psychiatrist's opinion based on his clinical skill, mature judgment, insight, objectivity, and humane understanding.

Nevertheless, the psychiatrist has had certain accepted clinical guidelines he could follow in forming his opinion to interrupt pregnancy for psychiatric reasons. For example, in the presence of such major mental disorders as schizophrenia and psychotic depression, with the accompanying risks of suicide and infanticide, or in situations in which pregnancy resulted from rape or occurred in a mentally retarded, incompetent girl, abortion would be considered justified by most psychiatrists.

CHANGING ATTITUDES TOWARD ABORTION

The guidelines and reasons for performing abortion are undergoing radical changes in the direction of greater permissiveness, and many modifications have already received legal sanction in a number of states. Many of these changes in attitude have resulted from psychosocial pressures, a fact which has placed the consulting psychiatrist in a role of special importance. Most requests for abortion today probably do not occur because of definable physical or mental illness, but rather because of the applicant's belief that the continuation of the pregnancy would bring upon her and her family "intolerable" hardships, possibly provoking a total breakdown in an already precarious psychosocial equilibrium within herself or her family structure. In such instances, the consulting psychiatrist can no longer use only his former clinical guidelines. He still evaluates a person's strengths and weaknesses, but also he has to make a much broader evaluation, namely, of psychosocial factors. He must attempt to determine whether the pregnancy does indeed constitute an "intolerable" hardship and does truly place in jeopardy the health and welfare of the patient and her family.

As the psychiatrist and his colleagues attempt to play the role of a Solomon, they must realize that significant psychosocial changes are taking place. They must be aware of those very real threats to life and health: oversized families, overcrowding, broken homes, poverty, crime, delinquency, and the depersonalizing influence of urban and ghetto life. Consideration must be given to the fact that there are different kinds of sickness — that there is social as well as medical and psychological sickness. The latter two may be more immediate and more in keeping with the physician's traditional experience and training, but an additional pregnancy may be just as inimical to social as to medical or psychological sickness.

THE PSYCHIATRIST'S DILEMMA

The changing nature and circumstances of illness and medical practice create problems for the psychiatrist and for all physicians. The doctor must rethink his position. Every act of the physician must be executed within the framework of clinical judgment and a set of values. What have become acceptable criteria to many physicians and laymen might not be acceptable to the individual psychiatrist or physician who has his own established basis for professional conduct. As greater latitude in the reasons for abortion is permitted, especially in reasons based on psychosocial factors, the doctor is moved further from his clinical base and from time-honored medical and psychological guidelines. The psychosocial basis for abortion is full of risks,

and in the face of harmful psychosocial conditions it is easy for both the doctor and the patient to rationalize the need for an abortion.

In fact, abortion on demand, without the supporting evidence of clinical need, is now a common event, because of such influences as feminine liberation movements, the undesirability of adding to the population explosion, pollution, and the breakdown of social order. This position, of course, bypasses the use of clinical judgment and makes the surgeon merely a technician who performs a procedure that was once taken seriously but is now often looked upon as little more than removal of an annoying wart from a person's finger.

NEW GUIDELINES FOR THE DOCTOR

25 The old guidelines will remain, but in the new milieu of medical practice new guidelines must also be considered. This is essential as long as physicians desire to practice medicine by exercising their judgment in the framework of clinical criteria and ethical and moral values. The following thoughts might be of help in adding new guidelines to the old ones.

First, a doctor should not surrender his legitimate responsibility to do what he believes is in his patient's best interest, no matter what her emotionally determined wishes are. To illustrate this point, in former years it was not uncommon for surgeons to operate on a patient for symptoms that obviously were of emotional and conversion origin. The doctor would rationalize his actions: "If I don't operate on her, someone else will." Or he might rationalize further: "If I take out her appendix (although it is normal), this will relieve her anxiety and hypochondriacal concern." Surgery on such a basis is no longer acceptable, and the doctor is expected to deal with the patient at the level of her emotional problem; if he is unable to do so, he is expected to refer the patient to someone who can.

Second, in spite of the profound changes in social attitudes that are taking place, an abortion should not be looked upon as a simple or necessarily innocuous act. Technically it may be a simple procedure, but psychologically a pregnancy has meaning to the person involved and carries important emotional and psychological implications. After all, there are still such human reactions as guilt and remorse and such factors as ideals and self-respect. Theoretically, an abortion should not be performed without considering these important aspects of human experience. An evaluation for an abortion should take into consideration the patient's life situation, her strengths and weaknesses, her motivations, and her amenability to psychological help and support. This kind of evaluation must be done within the conceptual framework of psychosocial and medical sickness.

Third, the basic goal of every psychiatrist (and physician) in his encounter with his patient, pregnant or not, is to help the patient deal with life problems in a mature, responsible, farsighted, adequate fashion. It is to be expected that the physician's goals will meet some resistance, because the patient's idea of how the problem should be solved is often different from the physician's idea. But resistance is part of the clinical problem, and the physician must learn to deal with it.

Many patients, when they are confronted with a life crisis such as a pregnancy, want someone to "bail" them out and take over their problem for them. It is true that some patients must be bailed out, as when acute toxemias, acute psychoses, or intolerable psychosocial conditions are present. But often patients should not be bailed out. Rather, the best thing one might do for them is to set limits that may not be manipulated, and to offer support and guidance to the patient as she is encouraged to deal with her own crisis (which after all may be of her own making and which is her responsibility to meet). To ask a person to take the responsibility for her own problem and to cope with it when she is able to do so may lead her to greater maturity and self-esteem and increased capacity for responsibility.

There are many instances when, in the interest of a patient's ultimate good, an abortion should not be performed. But such a decision should be arrived at only after careful and thoughtful consideration of all aspects of the problem, and the patient should be given maximum psychological help and support. I am sure that it has been the experience of every psychiatrist not to have acquiesced to the pleadings of a distraught mother or husband for an abortion on grounds that to them seemed perfectly reasonable, and later to have the parents find enormous satisfaction not only in the spared child but in their newfound strengths and insights.

SUMMARY

Abortion must be viewed in a broad conceptual framework of what constitutes health and illness and what constitutes a threat to life and health. The psychosocial dimension of sickness must be added to the physical and the psychological dimensions. There are psychosocial reasons for interrupting pregnancy; but they are not easily assessed, and they do open the way to permissiveness, manipulation, and "softheaded" decisions. Legitimate psychosocial contraindications to the continuation of pregnancy should be recognized and acted upon, however. (Honest men will differ from time to time in their opinions in this context.)

A guideline of special importance to the doctor is his awareness of his role in helping patients whenever possible to become mature, responsible persons. A person may find that learning to cope with life crises adequately — living with courage and honesty and the willingness to cope with problems when he has the resources to do so — makes life worthwhile.