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Termination of pregnancy on psychiatric grounds

The termination of pregnancy is largely a moral and ethical issue arising from the beliefs and values of a particular society. The medical indications are simply a matter of deciding on exemptions from the stringencies of the law for health reasons, and there are few of these, as witness the fact that only 353 were granted in South Africa in 1981 (94 for physical health, 185 for mental health and 74 for genetic reasons).[1] The purely medical and genetic indications are relatively clear-cut, as demonstrable gross abnormalities are always present in these cases, but the psychiatric indications are less well defined. There must be the 'likelihood of permanent damage to mental health', and this is extremely difficult to gauge because individual response to stress or the trauma of childbirth is very variable, and the recuperative capacity of any particular individual is difficult to judge. Furthermore, 'mental health' is a rather vague concept. There are in fact few if any psychiatric illnesses which warrant termination of pregnancy in their own right, not even severe depression with the risk of suicide since this is treatable and the law specifically states that the effects must be permanent. Social, humanitarian and other reasons may not be adduced, although no one would argue that they have to be considered as adjuvant factors in assessing mental health. Moreover, the literature does not offer a clear guide, as reports of consequences vary in different investigations and in different populations, and there is rarely certainty that untoward psychological effects will occur if pregnancy goes to term. Personality factors play an important part in the assessment but are notoriously difficult to measure, the best guide usually being a rule of thumb judgement based on the individual's previously demonstrated capacity to withstand strain.

The main difficulty is that the law requires rules which can be applied in a variety of circumstances and in a non-arbitrary fashion. Clinical judgements on the other hand, especially in an area such as psychiatry, which is in some respects still a young and uncertain science, cannot match this precision. Moreover, medicine has a biological framework, which often does not mesh with the man-made structure of the law. For these reasons decisions about pregnancy termination are among the most difficult in medicine, and those who are, as it were, on the cutting edge, particularly psychiatrists, have to operate at an interface of human distress, societal demands and medical need. This demands the highest clinical acumen, personal integrity and professional standards.

What then is the balance sheet after 7 years of the operation of the Abortion and Sterilization Act of 1975? The moral position of society has been maintained, yet termination of pregnancy has been made legal under certain conditions and allowance is made for extreme medical exceptions. Certainly the number of legal terminations is very small considering the birth rate and total population.

As far as individual women are concerned, many are disappointed or angered by negative decisions, although some have undoubtedly benefited because they have been brought into contact with skilled advisers including psychiatrists, social workers and psychologists. Quite apart from the material help that they offer, for instance in dealing with husbands, family or accommodation, an unwanted pregnancy often brings commitments and conflicts to the surface which have to do with marriage, motherhood, personal relationships, independence, or role in life and which may have been previously avoided or inadequately dealt with. This is especially so in the case of unmarried women and teenagers, and the pregnancy advisory services which have been developed in our larger cities have assisted many women to a deeper consideration of their situation, whether termination is eventually performed or not. For instance, ambivalence about the removal of a living fetus is common and can often be resolved in discussion. However, it must be said that there are many women whose material burdens and mental suffering would have been relieved in other societies by termination on social and/or humanitarian grounds. There is also well-founded medical concern about the children of obviously inadequate mothers who may not be aborted in terms of the law but whose emotional immaturity, personal maladjustment, or potential for neglect of an unwanted child do not augur well for its future.

We also have to face the reality that many women take matters into their own hands. Many go to other countries where abortion is available on demand or for social reasons, and in South Africa the number of operations for the removal of residues of pregnancy continues to rise. A total of 33 194 such operations was recorded for the period 1 December 1980 to 30 November 1981, and of these a large proportion are considered to be due to non-legal

attempts to procure abortion. There were, in fact, 1 446 septic miscarriages.

Termination of pregnancy remains a moral issue, but the experience gained by the medical profession regarding the consequences, whether it is recommended or not, and particularly in the sphere of gynaecology and mental health, is most important in gaining accurate information on a topic of great public concern.

1. Department of Health and Welfare. *Annual Report*. Pretoria: Government Printer, 1981.

Kindermishandeling

Van al die kliniese probleme in pediatrie en algemene praktyk is kindermishandeling een van die moeilikstes om voldoende te hanteer. Een van die basiese veronderstellings van kliniese pediatrie is dat die volwassene wat sy kind na die dokter bring, die kind se belange op sy hart dra, en om te aanvaar dat 'n ouer die oorsaak van sy kind se beserings kan wees, vereis 'n verandering in die dokter se houding wat baie moeilik kan wees om te maak, en selfs nog moeiliker kan wees om weg te steek van die ouer wat van mishandeling verdink word.

Watter ouer is die meeste geneig om sy kind aan te rand? Blykbaar hang dit in 'n sekere mate van die kind se ouderdom af, aangesien moeders meer geneig is om babas aan te rand terwyl vaders weer ouer kinders aanrand.[1] Kindermishandeling het niks met sosiale klas of die intelligensie van die ouers te doen nie, maar is skynbaar meer verwant aan die kinderjare van die ouer, waar emosionele ontneming die grondslag lê vir soortgelyke ondervindings in die volgende geslag. Alhoewel duidelike geestelike versteuring nie 'n algemene kenmerk van hierdie ouers is nie, is eensaamheid, verlies van ondersteuning van die uitgebreide gesin, gebrek aan ondersteuning van die gemeenskap en huweliksonmin almal relevante faktore.

Enige kind loop die gevaar om mishandel te word, maar veral twee groepe kan hier uitgesonder word — babas wat deur 'n keisersnit-verlossing gebore is, en dié met 'n lae geboortegewig. Volgens Jolly[1] vind die band tussen 'n moeder en haar nuwe baba nie outomaties plaas nie, en kan dit selfs misluk as hulle vir 'n tyd lank geskei word, soos wat wel gebeur as die baba vir observasie in die spesiale sorgeenheid opgeneem is. As dit nodig is (en dit moet nooit as 'n roetine gedoen word nie) behoort die moeder toegelaat te word om die baba te hanteer, selfs as hy in 'n broeikas is.

Hoe herken mens 'n kind wat mishandel is? 'n Goeie aanduiding is gewoonlik 'n teenstrydigheid tussen die geskiedenis en die kliniese voorkoms van die letsel, asook 'n moontlike tydsverloop tussen die toediening van die besering en die tyd wat die ouers die kind na die dokter bring. Die houdings van die ouers mag ook aanleiding tot agterdog gee, veral as hulle graad van aggressie buite verhouding is met die graad van die besering. Die kind kan in sulke omstandighede lusteloos, teruggetrokke en traag voorkom en mag 'n verskeidenheid van beserings, van kneusings van die vel tot brandwonde en bytmerke toon. Die mees algemene skeletbeserings is in uiterste gevalle op die skedel en ribbes.[2] Röntgenogramme is in baie gevalle van beperkte waarde en die diagnose behoort eerder op kliniese grondslag gedoen te word. 'n Volledige skeletondersoek van fisies-mishandelde kinders jonger as 1 jaar behoort egter gemaak te word. (In een studie het 22% van hierdie groep ongediagnoseerde frakture gehad.)

Watter stappe moet gedoen word as kindermishandeling vermoed word? Die eerste prioriteit is om die kind na 'n hospitaal te neem waar hy behoorlike sorg kan kry, en om verdere mishandeling te verhoed. As dit geweier word of, soos wat soms gebeur, as die dokter deur die bure ingelig word dat mishandeling plaasvind, maar hy het nie die kind gesien nie, kan daar met die Departement van Gesondheid en Welsyn in verbinding getree word, wat baie diskreet ondersoek sal instel na die probleem. 'n Lys van telefoonnommers is vir hierdie doel in die *Suid-Afrikaanse Mediese Tydskrif* van 26 Maart 1983 gepubliseer (bl. 507).

Alhoewel die fokus van onmiddellike belang die kind is, moet die benadering tot die ouers baie versigtig wees. Die meeste ouers wat hulle kinders mishandel is baie goed bewus van wat hulle gedoen het, en kritiese en veroordelende houdings is onvanpas. Onderskragende behandeling is nodig, en dit moet gedoen word deur vooggrootouers aan te stel of deur groepterapie toe te pas. Toesig van probleemgesinne is onontbeerlik om verdere mishandeling te verhoed omdat, watter stappe daar ook al teen die ouers gedoen word, die gesondheid en welsyn van die kind die eerste prioriteit is.

1. Jolly H. *Diseases of Children*. Oxford: Blackwell Scientific Publications, 1976: 622-626.
2. Merten DF, Radkowski MA, Leonidas JC. The abused child: radiological reappraisal. *Radiology* 1983; **146:** 377-381.