Registration of College Qualifications

The General Medical Council has resolved 'that the qualifications of Member and Fellow of the Royal College of Psychiatrists be recognized as registrable under Section 8 of the Medical Act, 1956, as amended by Section 11 of the Medical Act, 1969'.

The G.M.C. has indicated that it would be helpful if persons applying to register these qualifications would state:

(a) their full name;

(b) their registration number or (failing that) their date of registration with the Council; and

(c) the additional qualification which they wish to register, and the year in which they obtained it.

No fee is payable for the registration of additional qualifications.

Scottish Division

The Royal College of Physicians and Surgeons of Glasgow has decided to introduce a new category of Affiliate for Members and Fellows of other Colleges resident in the West of Scotland. It is anticipated that in the long term there will be increasing use of the College facilities as a centre for academic and related social purposes.

The Public Policy Committee of the Royal College of Psychiatrists has endorsed this venture, and the Secretary of the Scottish Division has been authorized to write to Scottish Fellows and Members drawing their attention to this new situation.

Chandos House

The *Journal* office has received several enquiries from readers as to whether copies of Miss Charlotte Halliday's drawing of the exterior of Chandos House, reproduced in the June issue of *News and Notes*, could be made available. There are probably many other psychiatrists who would like to have this very attractive drawing of the first home of their College in a form suitable for framing, and it has therefore been decided, with the agreement of Miss Halliday and the Royal Society of Medicine, to offer copies $13\frac{1}{4}$ in. $\times$ $9\frac{3}{4}$ in., on antique laid paper, at a cost of 20p each, including postage and packing. Orders, enclosing remittance (cheques should be made out to the Royal College of Psychiatrists), should be sent to the *Journal* office, Royal College of Psychiatrists, Chandos House, 2 Queen Anne Street, London, W1M 9LE.

SOME REFLECTIONS ON THERAPEUTIC ABORTION*

Abortion in Sweden

The Report on the Swedish Commission entitled *The Right to Abortion* has recently been published (1971). The Commission are able to point to the fact that comparatively few women need to undergo surgical abortion. They emphasize that no woman 'wants' the operation; all would prefer to avoid it. The measures that might be taken to reduce or avoid the need for abortion are considered under two headings: contraception and socially supportive measures. There should be a speeding up of the programmes for disseminating information about methods of birth control, and the authorities should improve services by allocating sufficient medical sessions to consultations about birth control. As regards social support, the Commission review in detail the assistance a woman can count on getting from the State if she wishes to have a child. The aim should be to give 'fundamental social and economic security' to the woman who wants a child as much as to the one who does not. They mention, for example, that the six-month period of 'job security' should be extended to one year, and make the interesting recommendation that the same rights ought to apply to the man, should it be he and not she who decides to care for the child. The Commission also recommend that the scope of the maternity and child health services be extended to include social and psychological advice, including help in domestic relationships, and that this advice should also be available to the man.

As regards abortion itself, the Commission is not in favour of its being legalized as a new method of birth control; it ought to be done only as a last resort. However, women should have the 'legal right' to undergo the operation. It would not, however, be a matter of abortion on request. One senses that this was a difficult area, but the proposal in effect is that when a woman does not want to have the child the

* The views expressed in this and the other signed articles are those of the individuals or bodies concerned and do not necessarily represent those of the College.

https://doi.org/10.1192/S0007125072302400 Published online by Cambridge University Press

'guiding principle' should be that she should have the abortion, *unless it is inadvisable because of the physical or psychological risks in the particular case*. It should be remembered that in Sweden many women who originally ask their doctor or the local advisory service for abortions are dissuaded, so that those who make formal application to the Medical Board are the more determined and those with the strongest claims. The Commission believes that special Boards including lay members should now be set up in hospitals to advise the obstetrician, and that the woman should have the right of appeal to a National Board.

Abortion and the Psychiatrist in Britain

In Britain the role of the psychiatrist is changing. He probably sees fewer patients than formerly, and of those he sees, many (at least in Newcastle upon Tyne) are referred not by general practitioners but by obstetricians who say that they think the patient needs psychiatric treatment, irrespective of the pregnancy, or that they are ready to terminate but are anxious about the possible harmful effects. Many women, of course, are not referred for psychiatric opinion, and in one series reported by Pare and Raven (1970) several (9 of 22) later regretted the operation, which suggests that it might have been helpful to have had a psychiatrist's opinion. But how is the psychiatrist to approach his task? The risks of suicide or of 'serious breakdown' are now acknowledged to be small, but as recent studies show (Clark *et al.*, 1968; Kenyon, 1969; Pare and Raven, 1970; Todd, 1971, 1972) psychiatrists are now recommending abortion in 50-70 per cent of women sent to them, and of married women in as many as 70-80 per cent. When one looks at the criteria on which the recommendations are based, one gets the impression that an attempt is made to weigh up various factors without any clear guiding principles as to their relative importance, and that the decisions arrived at are arbitrary ones, tilted as a whole in favour of termination for reasons it would be difficult in most cases to define very precisely in psychiatric terms.

Despite the rather high percentage of recommendations in favour of abortion, the pregnancy is in fact not completed in nearly half the cases in which the request is refused, so that only 1 in 4 or less of the women actually produce a live baby, and of these some do not keep it. On the other hand, only a few women regret the operation.

At present the decision seems to depend largely upon vague ideas about how much 'strain' or unhappiness a woman can bear, and as this will depend on the extent of her willingness to have and devote herself to the child her own attitude comes into focus as the central issue. If the psychiatrist accepts that unwillingness to continue the pregnancy constitutes a *prima facie* case for abortion he will have to reverse the traditional approach; instead of seeking 'psychiatric grounds' for abortion he must look for evidence that the pregnancy ought not to be interrupted. In other words, if he decides to be guided by the realities of the present situation he will need to learn to use his skills to identify those who would be harmed by abortion or would in the long run benefit by continuing the pregnancy. It would not then be a question of abortion on demand, but abortion unless there were contraindications to it. The decision would not necessarily be easier, but the premisses on which it was based might be found to be more logical.

If the attitude of the woman is to be the basic consideration, the psychiatrist's main task must be to assess the strength and genuineness of her feelings, and to elicit as clearly as he can the reasons for them. Sometimes it will transpire that it is the wish of others, rather than of the woman herself, that the abortion should take place, or her own feelings may be ambivalent or confused.

Her attitude may arise, it may be assumed, either from factors in her situation and environment, or from factors within herself, or from a combination of both, and it is important to try to examine them independently of one another, or the picture obtained will be blurred. The relative importance of the environmental and personal factors in women requesting abortion does not seem to have been systematically studied.

Factors in the situation and environment include, first, the 'facts', such as the woman's age (particularly the extremes of reproductive life) and marital state, her domestic, economic and career position, and whether others are dependent on her earnings. Her obstetrical and medical history, her parity, and the medical and psychiatric history of her husband and children may also be regarded as objective data. Other aspects, referring to the future, but still external to the woman in this context, include the husband's earning potential and employment prospects, the stability of the marriage, and the amount of support likely to be forthcoming from parents and relatives. In the case of the unmarried woman, the chances of the boyfriend marrying her need to be considered.

It would be valuable to try to quantify the individual areas of stress, and to obtain a measure of 'total stress' as experienced by women requesting abortion, and to make a comparison with control groups of women drawn from those attending ante-natal clinics. The groups would have to be matched for age and, if possible, marital status. So far as I know, no such comparison has been attempted, but it would appear to be an essential step in understanding the reasons

https://doi.org/10.1192/S0007125072302400 Published online by Cambridge University Press

that lead women to ask for abortion and in delineating the areas where prophylaxis or intervention might be possible. It would also help to focus attention on the group of cases where the external stresses are minimal and the desire for abortion arises from factors within the woman herself.

By *factors within the woman* is meant the psychiatric state, personality, temperament and emotional maturity, and earlier experiences that appear to affect her attitude to pregnancy and childbirth. One suspects that the formal diagnosis of the present state is often less illuminating than might be supposed; serious illnesses, such as schizophrenia or Huntington's chorea, are rarely met with, and 'reactive depression' merely reflects the fact that the pregnancy is unwanted. The personality and maturity of the woman are generally more important in determining her attitude, though they may not always influence the psychiatrist to make a recommendation in the direction one might assume they would. This is because, as Ekblad (1955) and others have noticed, the outcome of abortion tends to be most satisfactory in *previously stable* women (who in most cases have good reasons for wanting it), and single women who have come to terms with the fact that their prospects of marrying the father of the child are nil also do well after abortion. On the other hand, neurotic and inadequate women may be liable to feel guilty and have regrets unless they can find sufficient justification for their action in adverse circumstances. Young married women who are immature may be frightened of childbirth or feel anxious and inadequate about caring for a child, and in their case alternatives such as social and psychotherapeutic support should be very carefully considered. Refusal to collude with the patient's fears that she will be incapable of looking after the child may itself have a therapeutic effect and bring about a change in outlook. As a general rule, *when circumstances are favourable*, it will be wise to question whether abortion on grounds of 'inadequacy' or 'depression' is in the best interests of the patient, and to weigh up the possibilities of treatment. When the circumstances are unfavourable, as they usually are, particularly for single women, the psychiatrist may find that his own judgement coincides with the woman's assessment of the situation.

Sterilization in addition to termination of pregnancy is a separate issue, but if the woman wants to be sterilized, and particularly if she has previously requested it, it may be thought to confirm the strength and consistency of her wish not to have a child.

D. W. K. KAY.

REFERENCES

CLARK, M., FORSTNER, I., POND, D. A., and TREDGOLD, R. F. (1968). *Lancet, ii*, 501.

EKBLAD, M. (1955). *Acta psychiat. Scand.*, Suppl. 99.

KENYON, F. E. (1969). *Brit. J. med. Psychol.*, **42**, 243.

PARE, C. M. B., and RAVEN, H. (1970). *Lancet, i*, 635.

REPORT ON THE SWEDISH COMMISSION (1971). *The Right to Abortion*. Stockholm.

TODD, N. A. (1971). *Brit. J. Psychiat.*, **119**, 489.

—— (1972). *Brit. J. Psychiat.*, **120**, 645.

THE CASE OF GRAHAM YOUNG

It was entirely predictable that the affair of the poisoner, Graham Young, the Broadmoor patient who murdered two workmates and attempted to kill two others, should arouse a furore of public comment. A single incident of this kind suffices to call into question the entire administrative and legal framework for dealing with criminal offenders who are also psychiatric patients. The same day that Young was convicted the Home Secretary announced in the House of Commons that the case had led to an immediate, searching examination of the arrangements for discharging restricted patients. As a result, a number of changes had already been introduced aimed at strengthening still further the safeguards for the protection of the public. In addition, a three man committee, consisting of a Judge, a Professor of Psychiatry, and a Director of Social Services, had been set up to review the situation and suggest any further changes that should be made. Finally, steps were being taken to appoint an independent committee, under the chairmanship of Lord Butler, to conduct a fundamental review of the criminal law relating to mentally abnormal offenders and the facilities for the treatment of such persons.

The circumstances which provoked this immediate and massive reaction were unique. Young had been committed on a 15-year restriction order in 1962, at the age of 14, following poisoning attempts (fortunately none fatal) upon members of his family and a schoolmate. On the recommendation of the Broadmoor psychiatrists, he was discharged subject to conditions in February 1971; he was placed under the supervision of a probation officer and required to attend a psychiatric out-patient department. Subsequent evidence suggests that almost immediately he resumed an active interest in poisons and soon began administering them to casual acquaintances.

Killing for the pleasure of it, without significant personal interaction between offender and victim, is extremely rare. So is murder by former Broadmoor patients. In over a century before the Young episode, only one Broadmoor patient, admitted following

https://doi.org/10.1192/S0007125072302400 Published online by Cambridge University Press