EDITORIAL

FAMILY PLANNING AND MENTAL HEALTH

Family planning, as the name itself indicates, is not merely limitation of family size. It includes an important and often overlooked concept: that of spacing. A study conducted a few years ago (Kumar, 1976) noted that none of the interviewees seemed to have any ideas about spacing. It is this ignorance, lack of education and consequent poor implementation of a major national programme amongst the Indian population which has prompted one to assess the impact of an uncontrolled rise in population on health—particularly mental health.

The population question is, theoretically, two fold: one has to guard against too rapid an increase of population, and also against a decrease. However, practically, the Indian scene is primarily concerned with the former. Control of population has become a problem second to none. About population explosion we need not go into details—facts are available with most of us. Malthusian predictions, made in the 18th century, are coming true today. Saunders (1925) referred to an optimum density of population. The limits of this concept are already being surpassed in this country. The so-called natural checks (high infant mortality rate, high death rate) are themselves being checked as a result of better medical care and change of economic environment. According to the theory of demographic transition, a stage will come when birth rate will parallel death rate. However, this will take a long time—and do we have the capacity to wait? Evidently, no.

High population density may itself cause untoward psychological effects upon humans. Although available data does not allow us to conclude upon direct psychological effects of overcrowding, animal studies have definitely shown adverse sequelae of the same (Calhoun, 1962). In animals, overcrowding can influence both behaviour and physiological function. In man, there is a clear correlation between a very high population density and the prevalence of mental disorders, although no definite causal relationship has, as yet, been established (WHO, 1974). Even if evidence of a direct effect is lacking, it is clear that indirectly (through poverty, jobs, housing, disease, crime, etc.) it may result in considerable stress being placed on man—resulting in higher rates of mental illness. India is passing through an extended period of economic crisis, and an early respite from the vice-like grip of poverty and underdevelopment seems unthinkable. Amongst the myriad of reasons being offered, the one which stands out prominently is: the unequal equation between national resources/production and demand.

Family planning is, thus, the need of the day. The assessment of attitude of the people towards this concept is a primary need before we can embark upon any rigid programme—as was dramatically evidenced during the days of emergency. The decision to embrace family planning under pressure from the government has been shown to result into a so-called "social-protest" (Wig, 1974), wherein people complain more about side-effects of family planning methods. Hence, proper attitude-studies, aimed at eliciting favourable and unfavourable factors regards adoption of family planning techniques, are needed. Based upon the information derived from them, a comprehensive public-education programme will go a long way in influencing attitude of the people. Various cultural, educational, religious and age factors need to be tackled before one can expect results from population control/measure. Indians, deeply entrenched as they are in
religious and cultural beliefs, especially need more intensive education, more so in the rural sector.

This leads us to focus our attention on the individual family planning techniques. The rhythm method and coitus interruptus have obvious disqualifications, although they are readily propagated by some religions. Use of contraceptive pills has often been reported to produce depressive features in women; some women have, on the other hand, found them helpful in relieving menstrual depression (Kutner and Brown, 1972). Other psychiatric sequelae have been reported with contraceptive pills. Since oral contraceptives exert at least part of their effect at the hypothalamic level, they might influence the emergence of binge eating (Moskovitz and Lingao, 1979). Controlled Indian studies on this topic are very few and deserve greater attention. Vasectomy has often been shown to be followed with sex symptoms (4%—53%), irritability, poor concentration depression and multiple somatic complaints (Sawhney et al., 1970; Wig et al., 1973; Sethi and Nathawat, 1973). Tubectomy is followed by 3 sets of symptoms (Wig, 1979); menstrual, sexual and psychological. Symptoms in the latter two areas have variously been reported to be between 1.5 to 83%. Anxiety, depression, somatic complaints, memory impairment and psycho-neurosis are common psychological sequelae. Abortion studies (Goraya et al., 1975; Menon, 1976; Wig and Devi, 1975) indicate that following MTP the prevalence of symptoms is less than those following tubectomy or vasectomy (Wig, 1979). There is now a substantial data from many countries suggesting frequent psychological benefit and a low incidence of adverse psychological sequelae to abortion (WHO, 1980). The intra-uterine devices have been much less studied in India. However, two studies (Sharma, 1972; Wig and Singh, 1970) show that this technique is not significantly associated with psychological symptoms, though controlled studies are lacking.

It would be well to briefly consider the reasons for rejection of family planning methods in our country. Religious and socio-cultural beliefs are very often responsible for guiding the attitudes of a particular group or community of people (Sharma & Bhaskaran, 1970). These beliefs, in general, eschew the so-called ‘artificial’ methods of birth control. Religious, political, socio-cultural and personal biases, based upon erroneous information and misguided ideals need be transformed into constructive critical appraisals to finally result in acceptance and propagation of scientific tenets and principles of family planning. High infant mortality, which at one time was a valid reason for an equal (if not higher) birth-rate, has ceased to play a decisive role; yet, the high birth rate continues to overshoot its goal.

The burden, so to say, of the problem of birth control is now being sought to be equally divided between the male and the female. The first male contraceptive pill may be a reality soon.

This minimal assessment of existing literature on family planning and mental health makes one fact stand out—i.e. the need for more and better controlled studies to be undertaken in India at the earliest. The Advisory Committee on Medical Research (ACMR) in its 22nd session at Geneva (1981) also stressed the need for research into psychosocial factors and for health services research in relation to family planning. Various psychological sequelae of family planning methods need be looked into and the public assured of the safety of particular methods, or warned of expected problems, as the case may be. Only then will it be possible to implement effectively what is, at present, one of the most important national programmes. The early interest exhibited by psychiatrists towards mental health aspects of Family planning (Sethi et al., 1968 etc.) has to be
reinforced. We, therefore, urge the Central and the State Governments to utilize the expertise of the Behavioural Scientists in drawing up the strategies in Family Planning Programmes, towards ensuring its successful implementation.

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