*Volume VII*

*No. 75*

*October, 1969*

# The Right to Abortion: A Psychiatric View

*Formulated by*
*the Committee on Psychiatry and Law*

Group for the Advancement of Psychiatry

*Table of Contents*



This report is the sixth in a series of publications comprising Volume VII. For a list of other GAP publications on topics related to this subject, please see page 229.

*Additional copies of this GAP Publication No. 75 are available at the following prices: 1-9 copies, $1.00 each; 10-24 copies, list less 15 per cent; 25-99 copies, list less 20 per cent; 100-499 copies, list less 30 per cent.*

*Upon request the Publications Office of the Group for the Advancement of Psychiatry will provide a complete listing of GAP titles currently in print, quantity prices, and information on subscriptions assuring the receipt of new publications as they are released.*

*Orders amounting to less than $5.00 must be accompanied by remittance. All prices are subject to change without notice.*

*Please send your order and remittance to: Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, New York 10016.*

*Standard Book Number 87318-104-2*

*Library of Congress Catalog Card Number 62-2872*

*Printed in the United States of America*

*Second printing, July 1971*

*Copyright © 1969 by the Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, New York 10016.*

*All rights reserved. This report must not be reproduced in any form without written permission of the Group for the Advancement of Psychiatry, except by a reviewer, reporter, or commentator who wishes to quote brief passages.*

# STATEMENT OF PURPOSE

THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY has a membership of approximately 195 psychiatrists, organized in the form of a number of working committees that direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

THE RIGHT TO ABORTION: A PSYCHIATRIC VIEW *was formulated by the Committee on Psychiatry and Law.* The members of this committee as well as all other committees are listed below.*

*At the time this report was formulated by the Committee on Psychiatry and Law, it was under the chairmanship of Dr. Zigmond M. Lebensohn. The members of the committee wish to express their grateful acknowledgment for the assistance provided by its consultants on this study: Alice S. Rossi, Ph.D., Associate Professor, Department of Sociology and Anthropology, Goucher College, Towson, Maryland, and Ralph Slovenko, LL.B., Professor of Law, Wayne State University Law School, Detroit, Michigan.

COMMITTEE ON
PSYCHIATRY AND LAW
Alan A. Stone, Cambridge, Chr.
Edward T. Auer, St. Louis
John Donnelly, Hartford
Jay Katz, New Haven
Zigmond M. Lebensohn, Washington, D.C
Carl P. Malmquist, Minneapolis
Seymour Pollack, Los Angeles
Gene L. Usdin, New Orleans
Andrew S. Watson, Ann Arbor

COMMITTEE ON ADOLESCENCE
Joseph D. Noshpitz, Washington, D.C., Chr.
Warren J. Gadpaille, Denver
Mary O'Neil Hawkins, New York
Charles A. Malone, Philadelphia
Silvio J. Onesti, Jr., Boston
Vivian Rakoff, Toronto
Calvin F. Settlage, San Francisco
Sidney L. Werkman, Washington, D.C.

COMMITTEE ON AGING
Jack Weinberg, Chicago, Chr.
Robert N. Butler, Washington, D.C.
Alvin I. Goldfarb, New York
Lawrence F. Greenleigh, Los Angeles
Maurice E. Linden, Philadelphia
Prescott W. Thompson, Topeka
Montague Ullman, Brooklyn

COMMITTEE ON CHILD PSYCHIATRY
E. James Anthony, St. Louis, Chr.
Suzanne T. van Amerongen, Boston
James M. Bell, New Canaan, N.Y.
H. Donald Dunton, New York
Joseph M. Green, Madison, Wis.
John F. Kenward, Chicago
William S. Langford, New York
John F. McDermott, Jr., Honolulu
Exie E. Welsch, New York
Virginia N. Wilking, New York

COMMITTEE ON COLLEGE STUDENT
Harrison P. Eddy, New York, Chr.
Robert L. Arnstein, New Haven
Alfred Flarsheim, Chicago
Alan Frank, Albuquerque, N.M.
Malkah Tolpin Notman, Brookline, Mass.
Kent E. Robinson, Towson, Md.
Earle Silber, Washington, D.C.
Benson R. Snyder, Cambridge
Tom G. Stauffer, Scarsdale, N.Y.

COMMITTEE ON THE FAMILY
Norman L. Paul, Cambridge, Chr.
Israel Zwerling, New York
Ivan Boszormenyi-Nagy, Philadelphia
L. Murray Bowen, Chevy Chase
David Mendell, Houston
Joseph Satten, Topeka
Kurt O. Schlesinger, San Francisco
John P. Spiegel, Waltham, Mass.
Lyman C. Wynne, Bethesda

COMMITTEE ON
GOVERNMENTAL AGENCIES
Harold Rosen, Baltimore, Chr.
Calvin S. Drayer, Philadelphia
Edward O. Harper, Cleveland
John E. Nardini, Washington, D.C.
Donald B. Peterson, Fulton, Mo.
Robert L. Williams, Gainesville, Fla.

COMMITTEE ON
INTERNATIONAL RELATIONS
Byrant M. Wedge, West Medford, Mass., Chr.
Francis F. Barnes, Chevy Chase
Eugene Brody, Baltimore
William D. Davidson, Washington, D.C.
Joseph T. English, Washington, D.C.
Louis C. English, Pomona, N.Y.
Frank Fremont-Smith, Massapequa, N.Y.
Robert L. Leopold, Philadelphia
John A. P. Millet, New York
Alain J. Sanseigne, New York
Bertram Schaffner, New York
Mottram P. Torre, New Orleans

COMMITTEE ON MEDICAL EDUCATION
David R. Hawkins, Charlottesville, Chr.
Hugh T. Carmichael, Washington, D.C.
Robert S. Daniels, Chicago
Raymond Feldman, Boulder, Colo.
Saul I. Harrison, Ann Arbor
Harold I. Lief, Philadelphia
John E. Mack, Boston
William L. Peltz, Philadelphia
David S. Sanders, Los Angeles
Robert A. Senescu, Albuquerque, N.M.
Roy M. Whitman, Cincinnati



COMMITTEE ON
MENTAL HEALTH SERVICES
Lee G. Sewall, N. Little Rock, Ark., Chr.
Morris E. Chafetz, Boston
Merrill Eaton, Omaha
James B. Funkhouser, Richmond, Va.
Robert S. Garber, Belle Mead, N.J.
Ernest W. Klatte, Talmage, Calif.
Alan I. Levenson, Tucson, Ariz.
W. Walter Menninger, Topeka
Lucy D. Ozarin, Bethesda
Jack A. Wolford, Pittsburgh

COMMITTEE ON
MENTAL RETARDATION
Henry H. Work, Los Angeles, Chr.
Howard V. Bair, Parsons, Kans.
Peter W. Bowman, Pownal, Me.
Stuart M. Finch, Ann Arbor
Leo Madow, Philadelphia
Irving Philips, San Francisco
George Tarjan, Los Angeles
Warren T. Vaughan, Jr., San Mateo
Thomas G. Webster, Chevy Chase

COMMITTEE ON
PREVENTIVE PSYCHIATRY
Stephen Fleck, New Haven, Chr.
Gerald Caplan, Boston
Jules V. Coleman, New Haven
Leonard J. Duhl, Berkeley
Albert J. Glass, Oklahoma City
Benjamin Jeffries, Harper Woods, Mich.
E. James Lieberman, Washington, D.C.
Mary E. Mercer, Nyack, N.Y.
Herbert C. Modlin, Topeka
Harris B. Peck, Bronx, N.Y.
Marvin E. Perkins, New York
Harold M. Visotsky, Chicago

COMMITTEE ON
PSYCHIATRY AND RELIGION
Earl A. Loomis, Jr., New York, Chr.
Sidney S. Furst, New York
Stanley A. Leavy, New Haven
Albert J. Lubin, Woodside, Calif.
Mortimer Ostow, New York
Bernard L. Pacella, New York

COMMITTEE ON
PSYCHIATRY AND SOCIAL WORK
C. Knight Aldrich, Chicago, Chr.
Maurice R. Friend, New York
John A. MacLeod, Cincinnati
John C. Nemiah, Boston
Eleanor A. Steele, Denver

COMMITTEE ON
PSYCHIATRY IN INDUSTRY
Harry H. Wagenheim, Philadelphia, Chr.
Spencer Bayles, Houston
Thomas L. Brannick, Rochester, Minn.
Herbert L. Klemme, Topeka
Jeptha R. MacFarlane, Westbury, N.Y.
Alan A. McLean, New York
Kenneth J. Munden, Memphis
Clarence J. Rowe, St. Paul
Graham C. Taylor, Montreal

COMMITTEE ON PSYCHOPATHOLOGY
Albert J. Silverman, New Brunswick, N.J., Chr.
Wagner H. Bridger, New York
Neil R. Burch, Houston
Sanford I. Cohen, New Orleans
Daniel X. Freedman, Chicago
Milton Greenblatt, Boston
Paul E. Huston, Iowa City
P. Herbert Leiderman, Palo Alto, Calif.
Jack H. Mendelson, Chevy Chase
Richard E. Renneker, Los Angeles
George E. Ruff, Philadelphia
Charles Shagass, Philadelphia
George E. Vaillant, Boston

COMMITTEE ON PUBLIC EDUCATION
Peter A. Martin, Detroit, Chr.
Leo H. Bartemeier, Baltimore
H. Waldo Bird, El Paso, Texas
Lloyd C. Elam, Nashville
Dana L. Farnsworth, Cambridge
James A. Knight, New Orleans
John P. Lambert, Katonah, N.Y.
Mildred Mitchell-Bateman, Charleston
Mabel Ross, Boston
Julius Schreiber, Washington, D.C.
Miles F. Shore, Boston
Kent A. Zimmerman, Berkeley

COMMITTEE ON RESEARCH
Morris A. Lipton, Chapel Hill, Chr.
Stanley Eldred, Belmont, Mass.
Louis A. Gottschalk, Irvine, Calif.
Sheppard G. Kellam, Chicago
Donald F. Klein, Glen Oaks, N.Y.
Gerald L. Klerman, New Haven
Ralph R. Notman, Brookline, Mass.
Alfred H. Stanton, Belmont, Mass.

Eberhard H. Uhlenhuth, Chicago

COMMITTEE ON SOCIAL ISSUES
Perry Ottenberg, Philadelphia, Chr.
Viola W. Bernard, New York
Lester Grinspoon, Boston
Joel S. Handler, Chicago
Judd Marmor, Los Angeles
Roy W. Menninger, Topeka
Arthur A. Miller, Chicago
Peter B. Neubauer, New York
Charles A. Pinderhughes, Boston
Kendon W. Smith, Piermont, N.Y.

COMMITTEE ON THERAPEUTIC CARE
Bernard H. Hall, Topeka, Chr.
Ian L. W. Clancey, Ottawa
Thomas E. Curtis, Chapel Hill
Robert W. Gibson, Towson, Md.
Harold A. Greenberg, Bethesda
Henry U. Grunebaum, Boston
Lester H. Rudy, Chicago
Melvin Sabshin, Chicago
Benjamin Simon, Boston
Robert E. Switzer, Topeka

COMMITTEE ON THERAPY
Peter H. Knapp, Boston, Chr.
Henry W. Brosin, Pittsburgh
Eugene Meyer, Baltimore
William C. Offenkrantz, Chicago
Lewis L. Robbins, Glen Oaks, N.Y.
Albert E. Scheflen, Bronx, N.Y.
Harley C. Shands, New York
Lucia E. Tower, Chicago

---

Malcolm J. Farrell, Waverley, Mass.

CONTRIBUTING MEMBERS
Marvin L. Adland, Chevy Chase
Carlos C. Alden, Jr., Williamsville, N. Y.
William H. Anderson, Lansing, Mich.
Kenneth E. Appel, Ardmore, Pa.
M. Royden C. Astley, Pittsburgh
Charlotte Babcock, Pittsburgh
Grace Baker, New York
Bernard Bandler, Boston
Walter E. Barton, Washington, D.C.
Anne R. Benjamin, Chicago
Ivan C. Berlien, Coral Gables, Fla.
Sidney Berman, Washington, D.C.
Grete L. Bibring, Cambridge
Edward G. Billings, Denver
Carl A. L. Binger, Cambridge
Wilfred Bloomberg, Hartford
C. H. Hardin Branch, Salt Lake City
Matthew Brody, Brooklyn
Ewald W. Busse, Durham
Dale C. Cameron, Geneva
Norman Cameron, New Haven
Robert Coles, Cambridge
Harvey H. Corman, New York
Frank J. Curran, New York
Bernard L. Diamond, Berkeley
Franklin G. Ebaugh, Denver
Joel Elkes, Baltimore
O. Spurgeon English, Narbeth, Pa.
Jack R. Ewalt, Boston
James H. Ewing, Wallingford, Pa.
Edward C. Frank, Louisville
Lawrence Z. Freedman, Chicago
Moses M. Frohlich, Ann Arbor
Daniel H. Funkenstein, Boston
Maurice H. Greenhill, Scarsdale, N.Y.
John H. Greist, Indianapolis
Roy R. Grinker, Chicago
Ernest M. Gruenberg, Poughkeepsie, N. Y.
Herbert I. Harris, Boston
J. Cotter Hirschberg, Topeka
Edward J. Hornick, New York
Roger William Howell, Ann Arbor
Joseph Hughes, Philadelphia
Portia Bell Hume, Berkeley
Robert W. Hyde, Waterbury, Vt.
Lucie Jessner, Washington, D.C.
Irene M. Josselyn, Phoenix
Marion E. Kenworthy, New York
Othilda Krug, Cincinnati
Lawrence S. Kubie, Sparks, Md.
Paul V. Lemkau, Baltimore
Maurice Levine, Cincinnati
David M. Levy, New York
Robert J. Lifton, Woodbridge, Conn.
Erich Lindemann, Boston
Reginald S. Lourie, Washington, D.C.
Alfred O. Ludwig, Boston
Sydney G. Margolin, Denver
Helen V. McLean, Chicago
Karl Menninger, Topeka
James G. Miller, Cleveland
Angel N. Miranda, Hato Rey, P.R.
Rudolph G. Novick, Lincolnwood, Ill.
Francis J. O'Neill, Central Islip, N.J.
Humphry F. Osmond, Princeton, N.J.
Dane G. Prugh, Denver



Franz K. Reichsman, Brooklyn
Eveoleen N. Rexford, Cambridge
Milton Rosenbaum, New York
Mathew Ross, Chestnut Hill, Mass.
W. Donald Ross, Cincinnati
Elvin V. Semrad, Boston
Edward Stainbrook, Los Angeles
Brandt F. Steele, Denver
Rutherford B. Stevens, New York
Lloyd J. Thompson, Chapel Hill
Harvey J. Tompkins, New York
Arthur F. Valenstein, Cambridge
Helen Stochen Wagenheim, Philadelphia
Raymond W. Waggoner, Ann Arbor
Robert S. Wallerstein, San Francisco
Edward M. Weinshel, San Francisco
Joseph B. Wheelwright, San Francisco
Cecil L. Wittson, Omaha
David Wright, Providence
Stanley F. Yolles, Bethesda

LIFE MEMBERS

S. Spafford Ackerly, Louisville
Hyman S. Lippman, St. Paul
Bruce Robinson, Culver, Ind.
Francis H. Sleeper, Augusta, Me.

OFFICERS

*President*

John Donnelly
200 Retreat Avenue
Hartford, Conn. 06102

*Vice President*

George Tarjan
760 Westwood Plaza
Los Angeles, Calif. 90024

*Secretary-Treasurer*

Jack A. Wolford
3811 O'Hara Street
Pittsburgh, Penna. 15213

*Asst. Secretary-Treasurer*

Jack Weinberg
1601 W. Taylor Street
Chicago, Ill. 60612

PUBLICATIONS BOARD

*Chairman*

John C. Nemiah
330 Brookline Avenue
Boston, Mass. 02215

Hugh T. Carmichael
Louis A. Gottschalk
Bernard M. Hall
Perry Ottenberg
Bryant M. Wedge
Henry H. Work

*Consultant*

Milton Greenblatt

# THE RIGHT TO ABORTION: A PSYCHIATRIC VIEW

## Introduction

During the past two decades there has been an increasing tendency to invoke the psychiatrist as the arbiter at critical points of conflict between existing social policy and individual dissent and disagreement; abortion is one such instance of this tendency. Psychiatrists do have a relevant contribution to make to a resolution of the abortion dilemma, but their contribution is limited. When the psychiatrist serves as the *deus ex machina* of the conflicted social system, he may ease the immediate stress without clarifying or resolving the underlying divisiveness of the community. The unfortunate consequences of this are that society places undue responsibility upon the individual psychiatrist and at the same time shuns its own responsibility to face squarely the serious and sometimes critical issues that have led to such divisiveness. Because of these considerations and because the regulation of access to abortion is, in fact, the product of religious, moral, ethical, socioeconomic, political, and legal considerations, in what follows psychiatric factors are examined in relation to these broader perspectives.

## The Obligations of Motherhood

Mothering is a task that requires enormous human and emotional resources. It is an obligation that confronts and challenges the woman's capacity to care night and day. Done in the spirit

of love and fulfillment, it is hard but rewarding work. But when the child is unwanted, the task may become onerous and obligations created by such motherhood may become a lifetime sentence, an ordeal emotionally destructive to the mother and disastrous for the child. Despite these serious psychological consequences, motherhood is so universally revered as a natural fulfillment of the life cycle and as a sacred obligation to the potential of a new life that once the woman becomes pregnant, we tend to ignore the element of choice or to condemn those who in a variety of situations would choose abortion. It is out of this social, religious, and psychological climate that laws regulating abortion have been drawn.*

Abortion laws as currently enacted[1, 2] (including those "liberalized" under the American Law Institute's Model Statute[3]) require virtually all women, married or single, old or young, to carry the fetus to term and as a consequence in many instances to serve a lifetime sentence.[4] The married woman who becomes pregnant by inadvertence, the young girl who becomes pregnant out of inexperience, the promiscuous woman who becomes pregnant out of indiscretion are all subject to this same sentence. Once the error has been made, none of these women has the right to control her own fate unless she can prove to doctors that her mental or physical health is in danger.[5] In some states abortion is allowed only when the mother's death is imminent.[6]

A young society desperately in need of population and manpower perhaps might expect its women to make this sacrifice. But Western society today, on the contrary, is threatened by overpopulation,[7] and yet women are legally forced to fulfill a biological function that, when it is unwanted, has no rational justification from this perspective of the state. No abortion statute (except perhaps the Japanese[2]) has been enacted that takes into account this specific problem of overpopulation. Such a statute would suggest recognition and legitimization of the

* Some writers have emphasized the "masculinist" aspect of this problem as central to a proper psychological understanding of the law.



fact that abortion constitutes a secondary means of "contraception" and planned motherhood in an overpopulated society.

**Religious and Moral Objections to Abortion**

There can be no doubt that strong religious ideals contribute to sustaining the system of legal sanctions that makes abortion a source of guilt and labels it a crime.[8] Thus, in Roman Catholic doctrine, as the legal scholar Father Robert F. Drinan, S.J., states, "An abortion is the taking of the life of an unborn but, nevertheless, a real human being."[9] However, he argues that traditional abortion law is not simply the translation of "the views of his religion into the civil law . . . to impose them on others."[9] He defends this view by various constitutional and criminal law arguments,[10] but concedes that the Judeo-Christian religious tradition "in fact is probably the principal source of Anglo-American law . . . which regulates conduct deemed to constitute a crime against society."[9] Basic to Father Drinan's view (and this is shared by theologians of many religious persuasions) is the concept of the "inviolability of every human life" and the Roman Catholic dictum that the embryo should from the moment of conception be considered a human life. However, we should point out that, in the course of history, both the Roman Catholic Church and English law have altered their judgment as to the time at which the embryo should be considered a human life.[11] For centuries, in both English law and Roman Catholic dogma, abortion was not considered to have occurred until quickening.* At the very least this suggests that the religious definition of abortion has not always been precise. Indeed, many people and some religious groups[12] currently *do not* consider abortion before quickening the equivalent of murder.

Even our abortion laws as they now are applied and our technological advances in the birth control field betray a basic

* Quickening is the first recognizable movement of the fetus *in utero*, appearing from the fourth to the fifth month of pregnancy.

equivocation regarding the question of abortion and the implicit moral issues of "when life begins" and what constitutes the "taking of a life." Were our society convinced that abortion is murder, it would exact the same penalty against abortionists as is levied against other parties to premeditated murder—life imprisonment or even capital punishment. Of course our society does no such thing.[13] Moreover, as Garrett Hardin pointed out:

> If abortion is a crime, then the woman who aborts is certainly a criminal. . . . If a crime, it is a most remarkable one in that it is the only crime for which we prosecute the accessories to the crime and never the principal herself.[14]

Just as the curious application of the criminal law itself indicates ambiguity and doubt in our attitudes about abortion, so does our reaction to technological progress in developing methods of birth control. The "loop" or IUDs (intra-uterine devices) and the experimental "morning-after" pills prevent development of the fetus by halting the implantation of the fertilized egg in the uterine wall. Some authorities flatly contend that in the case of the IUDs a spontaneous abortion takes place a few weeks after implantation. At any rate, the function of these chemical and mechanical means of birth control is probably to interrupt the pregnancy *after* conception has taken place. In so doing, these contraceptives have made it all the more difficult to delineate contraception from abortion.[15] Perhaps the fact that no legal authorities are really concerned whether such devices are, in fact, abortifacients casts further doubt on the wisdom of attempting to bind all members of our society to a monolithic judgment that regards all abortions as murders.

As psychiatrists we fully recognize that for some women the sanctity of motherhood comes from a combination of both religious belief and a sense of personal fulfillment. We also recognize that for other women the sanctity of motherhood derives *solely* from the sense of personal or marital fulfillment. Even if this latter group were a small minority, their choice about



motherhood ought not be bound by the religious convictions of the majority. This established principle suggests that to the extent the law does translate secular and religious values into criminal sanction, some legal justification might be found not only for permitting these women to obtain abortion, but for permitting them to obtain such abortions with dignity and privacy and without public stigma.

Despite the foregoing considerations, many will argue as does Father Drinan that abortion constitutes murder and/or that it violates the rights of the unborn embryo. For those who take this moral stand there perhaps can be no absolute rebuttal, and certainly those who take this position will themselves avoid abortion and will be shocked by those who condone it.*

**The Rights of the Woman**

Against the seemingly insoluble problems presented by the "moral issue" of abortion, we must balance the consideration owed to the basic tenet of a democratic society: that people should be permitted to exercise a maximum degree of individual freedom, bound only by a proper regard for the legitimate rights of other citizens. We submit that under the current system of law, by denying a woman the right to rectify error through the process of abortion our statutes stand foursquare against her right to control her own reproductive life.

A particularly repugnant feature of current practice is that the economically affluent do not find it difficult to procure a "therapeutic" abortion. Thus, it is amply clear that a majority of "therapeutic" abortions are performed on private as opposed to clinic patients.[18] For example, one study found 20 times more private than clinic cases.[19] Similarly, the wealthy may afford the high fees charged by most of those competent practitioners

* It is important to add that some Roman Catholic authorities have indicated that they, too, believe that specific law is not needed to support specific Roman Catholic principle. Thus, Richard Cardinal Cushing of Boston is quoted as saying that Catholics do not need the law to support their moral principles.[16] Father Drinan has stated that he would prefer no law if the alternative was to be a liberalized law.[17]

who are willing to take the risks of performing an illegal abortion. Furthermore, there are various places in the world where a woman can readily obtain an abortion if she can afford the trip.[20] Thus, the law does not effectively prohibit the "right to abortion" to the affluent.[21]

Those who cannot afford the high fee of competent abortionists have other means of resolving their social difficulties. They are driven by their need into the hands of practitioners and charlatans who may employ dangerous techniques for inducing abortion. It is from this large sector of the population that the unnecessary deaths and complications are drawn as a result of incompetence.[22] In addition to the serious dangers of the procedures under these circumstances, women in this situation must suffer emotional experiences hardly to be surpassed for their sordid, demeaning, and shame-inducing character.[23] It can be said, then, that current laws as enforced have in fact done little to alter the large number of criminal and illegal abortions carried out in our society. Although statistics for the United States can be challenged, the data suggest a minimum of 100,000 abortions a year, and some estimates indicate there may be more than a million.[24] If the maximum estimate should prove correct, this would mean that one embryo is aborted for every four children who are born. Whichever estimate is correct, unquestionably the vast majority of these abortions are illegal and therefore not performed under optimal medical or psychological conditions. Thus, decisions are made individually and personally, responsive to social, economic, moral, religious, and psychological factors, regardless of the status of the law. The noted psychoanalyst Helene Deutsch has commented on this aspect of the problem as follows:

> Public opinion, common sense, and normal moral judgment supports the woman's human right to be a mother or to avoid being a mother by any of the means at her disposal according to her wishes. . . . The normal emotional reaction to abortion is overwhelmingly in the most varied civilizations to take the woman's part despite any laws to the contrary.[25]



**The Unwanted Child**

The predicament of the future child, should he be born, also cannot be ignored. More systematic research in this area is badly needed, but one significant study has been carried out in Sweden with 120 children born after an application for a therapeutic abortion had been refused.[26] These children were born during the 1939-41 period and followed up until age 21 for assessment in terms of mental health, social adjustment, and educational level. They were compared to a control group composed of the very next same-sexed child born at the same hospital or in the same district to other mothers. The mothers of the control group were not selected on the basis of their maturity, but simply by the criteria of proximity in time, in geography, and in the sex of offspring. The results of this study indicated that "The unwanted children were worse off in every respect. . . . The differences were often significant (statistically) and when they were not, they pointed in the same direction . . . to a worse lot for the unwanted child." This is certainly not unexpected since the adverse consequences of maternal rejection have long been recognized by psychiatrists as one of the major contributing elements of human psychopathology.[27] In fact, some psychiatrists believe that one of the most important goals of preventive psychiatry is the prevention of "unwanted offspring."[28]

Surely, in the face of the population explosion society no longer has a need to compel the birth of such unwanted children. To the contrary, an informed and timely social policy should emphasize that for the sake of the family as well as society such children as are born should be wanted. Stressing this point, Garrett Hardin referred to the positive aspect of abortion:

> Critics of abortion generally see it as an exclusively negative thing, a means of nonfulfillment only. What they fail to realize is that abortion, like other means of birth control, can lead to fulfillment in the life of a woman. A woman who aborts this year because she is in poor health, neurotic, economically harassed, unmarried, on the verge of divorce, or immature, may well decide to have some other child five years from now

—a wanted child. If her need for abortion is frustrated she may never know the joy of a wanted child.[29]

**Other Considerations**

While many other social, moral, and pragmatic goals may be offered as rationale for retaining the sanctions against abortion, our observation suggests that the historical and scientific developments of the past two decades have attenuated many of these factors. Some examples will illustrate this.

In the past, the threat or fear of pregancy supported our society's taboos about virginity. Whether or not one supports strict sexual sanctions, it is clear that the widespread availability of chemical and mechanical contraceptives has already eroded this traditional fear of pregnancy in many segments of society. Threat of pregnancy as a support of sexual morality and virginity has therefore lost some of its deterrent effect. Furthermore, we would suggest that the psychological cost of unwanted children far outweighs the limited gain in sexual morality that results from the fear of pregnancy.

Abortion at one time constituted a serious surgical procedure; considerable morbidity and some deaths were attendant to it. However, modern surgical techniques together with antibiotics have minimized these risks. The development of the vacuum evacuation procedure has already reduced morbidity and mortality to the status of insignificant factors.[30] Finally, the advent of a new class of risk-free abortifacient drugs can potentially make the interruption of pregnancy a nonsurgical procedure. This would mean that every practicing physician, on a simple prescriptive basis, would be able to terminate pregnancy harmlessly within the early phase of gestation. These developments make it clear that the element of physical risk to the pregnant woman is so small as to be negligible at this point in time and that the risk will, if anything, be still less in the future. These facts make it even more tragic that many American women are forced to seek criminal abortions wherein the risk of morbidity and mortality is relatively high.



An opinion frequently proffered by both medical and non-medical authorities argues that a woman who aborts undergoes adverse psychological sequelae.[31] One typical view holds that the normal psychophysiological depression that ensues on the interruption of pregnancy combines with a feeling of guilt to produce a focal point for future depressive episodes and that abortion may even in some cases precipitate psychosis or serious neurosis. The published evidence dealing with this supposed deleterious impact of abortion has been summarized by Simon and Senturia[32] and meticulously reviewed by Sloane.[24] Sloane concluded that the earlier findings of serious psychiatric sequelae are (a) often based on a statistically biased self-selection of subjects or are simply case studies without efforts to standardize the sample or balance it against a control group;[33] (b) inadequately differentiated as to pre-existing conditions and abortion sequelae; (c) highly variable (in one study, for example, 43 per cent[34] of aborted women showed moderate to severe guilt, while in another study none of the women could be so designated[35]). Furthermore, the recent more carefully studied cases of Simon,[36] Peck, and Marcus[37] suggest that women who in psychiatric terms are relatively normal respond to abortion with only a mild and self-limited depression without significant symptomatic sequelae. Psychiatrically disturbed women who undergo abortion for the most part remain stabilized or even improve. Simon's excellent retrospective study on women who were therapeutically aborted concludes:

> Our study did not produce support for the frequently expressed belief that therapeutic abortion results in involuntary infertility, difficulty in sexual relations, or is a precipitant in involutional depression.[36]

Thus, the dire predictions of dangerous sequelae that had become embedded in medical teaching have not been fulfilled in controlled clinical studies or in our own clinical experience, particularly if the woman was strongly motivated in her desire for an abortion. There are exceptions, of course, but the most

notable of these seem to occur when the woman becomes sterile as a consequence of infection at the time of her abortion.[25] The sterility means she can never restitute her loss by attaining motherhood in more gratifying circumstances. Since this occurs most often in nonmedical, illegal abortion, its significance could be markedly reduced if abortion were legalized.

Finally, during the 1950's it had been quite difficult for couples who are themselves sterile to adopt children. It had been an era of black market babies, of long waiting and stringent selection of adoptive parents. The past few years have brought a reversal in this trend; in many urban areas it is currently impossible to find adequate foster parents for unwanted infants.[38] The woman who continues the pregnancy of an unwanted child in the hope of finding foster parents for her baby is quite apt to be disappointed. Thus, this justification for requiring the unwilling mother to lend her body to the continued obligation of pregnancy has also diminished.

### The American Law Institute's "Liberalized" Abortion Law

The protagonists for reform of abortion laws have generally embraced the proposals of the American Law Institute:[3]

> A licensed physician is justified in terminating a pregnancy if:
>
> (a) he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or the pregnancy resulted from rape by force or its equivalent as defined in Section 207.4(1) or from incest as defined in Section 207.3; and
>
> (b) two physicians, one of whom may be the person performing the abortion, have certified in writing their belief in the justifying circumstances, and have filed such certificate prior to the abortion in the licensed hospital where it was to be performed, or in such other place as may be designated by law.

For a number of reasons we find the ALI proposals unsatisfactory.

First, for those insistent upon developing a statute that provides a social "resolution" of the moral issues, the ALI proposal is clearly of no help. For those convinced that abortion is murder, the ALI statute is nothing but a broadened license for professionals to authorize murder.[39] For those convinced, as we are, that the moral issues present an insoluble dilemma that should be left to individual conscience rather than be the subject of a social policy judgment, the ALI proposal disregards the right of a woman to control her own life.



A second objection must be voiced specifically to the extent of the role assigned psychiatrists. In an effort to liberalize the law in this field, the ALI proposal makes provision for abortion where a psychiatrist has found "substantial risk" that continuance of the pregnancy would gravely impair the mental health of the woman. Some legal criticism suggests that these "medico-legal standards" of "substantial risk," "gravely impair," and even "mental health" defy objective or consistent interpretations. Louisell argues that there is "nothing in the statute which would aid the physician in making the determination. At the very least the statutory language provides a fertile ground for the application of individual subjective notions. . . ."[40]

There are indeed studies that suggest that this criticism is just and that it applies to statutes in existence for many years as well as to the ALI. Thus we find that the rate of therapeutic abortion varies dramatically from hospital to hospital within a state, even though supposedly governed by the same statutes.[41] There is also variation in specific interpretation of the statute by different psychiatrists as demonstrated in several questionnaire studies.[2] Although differing hospital policies explain some of the variations in abortion rates, the reports that demonstrate the wide variation in psychiatric opinion as to which pregnant women conform to the standards of the statute raise serious doubts about the reliability of psychiatric determinations.

The crucial question to be answered is: Are there psychiatric criteria that can be consistently and validly applied in the face of an ambiguous medico-legal standard?

Consistency is used here in a simple statistical sense; that is, are there criteria that different experts will be able to apply in an objective and systematic fashion, or that the same expert will be able to apply objectively and systematically on different occasions? An assessment of the consistency of psychiatric criteria must include some consideration of such matters as the inherent ambiguity of the relevant clinical phenomena to be described, the extent to which psychiatric as distinct from legal criteria leave wide discretionary powers to the psychiatrist, and so forth. Validity is also used in a statistical sense; that is, are there in fact data suggesting that psychiatric criteria, when consistently applied, successfully predict grave impairment of a woman's mental health by her continued pregnancy and childbirth? This distinction between consistency and validity is meant to emphasize that even if psychiatrists of diverse background and training could rate patients for abortion in a consistent way, it still might be true that abortion is in fact beneficial to all or to none of the women who request it, no matter how they are rated.

We shall first consider the question of consistency. The following circumscribed and traditional criteria, although infrequently encountered, could probably be consistently applied by different psychiatrists when consulted on the advisability of abortion:[42]

(1) When previous pregnancies have repeatedly precipitated post-partum psychotic reactions.

(2) When the mother has been previously lobotomized.

(3) When the mother is a clear-cut "process" schizophrenic or is in the throes of an acute schizophrenic episode.

(4) When the mother has a severe and recurrent affective disorder.

(5) When there are profound suicidal or homicidal tendencies.

A second group of criteria are more ambiguous, but far more



often used by psychiatrists to characterize women requesting abortion:[43]

(1) The presence of mild suicidal ideation or suicidal gestures in a woman who might be treated by brief hospitalization or outpatient care.[44]

(2) Symptoms of mild neurosis or characterological problems.

(3) Situations where the mother has pronounced emotional or intellectual immaturity and is likely to be incapable of raising her child or coping with motherhood.

(4) A broad range of socioeconomic factors that create serious psychological hardship for the mother.

Almost any woman who wants an abortion might fit this second set of criteria and thus might be considered as fitting the medicolegal standard of "substantial risk" to "mental health" by some psychiatrists.

Patients who fit the first set of criteria are in a minority of those requesting abortion, but even such easily distinguished cases as these are disputable as to the validity of the "therapeutic indication."

The major question of *valid* psychiatric therapeutic indication to be decided is: Will the abortion and *its* effects be more traumatic than pregnancy, childbirth, and forced motherhood? Since our predictive criteria rarely foretell with any certainty what happens to the mother when abortion is denied, they have little if any proven validity. Indeed, in the opinion of Dr. Myre Sim, a British psychiatrist, "There are no psychiatric grounds for termination of pregnancy,"[45] and the psychiatrist "has no factual basis for being associated with the problem."[46]

Dr. R. Bruce Sloane has been only slightly less categorical: "There are no unequivocal psychiatric indications for therapeutic abortion."[24] Dr. Sloane's judgment, based on his review of published studies, is that "The risk of exacerbation or precipitation of a psychosis is small and *unpredictable,* and suicide [is] rare."[24]

Most often the psychiatrist finds psychodynamic considerations that are in conflict on this matter.[47] Which side of the ambivalence he chooses to support may well be based on some unarticulated moral, social, or policy judgment rather than on individual clinical considerations. Thus we agree with Dr. Joseph Rheingold in questioning the propriety of calling upon individual psychiatrists to be the ultimate decision makers on behalf of society. Dr. Rheingold has written:

> The explanation of the inconsistency of attitude (on the part of psychiatrists) lies both in the psychiatrist himself and in the complexity of the situations under judgment. Apart from his religious convictions, the psychatrist is influenced by his ethical and philosophical leanings, his social values, his professional associations, and the abortion 'taboo' among physicians, the pressures put upon him and his unconscious dispositions. The methodological approach, too, is variable. . . . The psychiatrist may or may not take into account humanitarian factors, the socioeconomic situation, the woman's significant relationships, eugenic possibilities, and the quality of prospective motherhood. He may conform to the letter of the law, he may allow himself a very liberal interpretation of it, or in good faith, he may use subterfuge to bring his findings into consonance with the law. . . . He may err in either direction: the woman may be aborted, with regrettable consequence, or she may not be aborted, with regrettable consequences.[48]

Doubtless many psychiatrists will continue to work within the ALI and similar current legal systems in the hope of helping individual patients who want an abortion. However, we believe it essential that psychiatrists, through their professional associations, begin to recognize their own limitations and back away from the invitation to accept responsibility for making decisions that more appropriately rest in the broader community. Although we cannot agree with the categorical nature of Dr. Sim's judgment, his words go to the heart of the issue: "If society wants abortion to be easier, it should have the courage to campaign for it honestly and not exploit the psychiatrist. . . ."[49]

An unfortunate consequence of the specific psychiatric provision for therapeutic abortion arises when women correctly



perceive that claims of psychiatric illness offer the only significant new opportunity for obtaining a legal abortion. They are, therefore, either tempted to malinger or led unconsciously to emphasize their psychiatric symptoms. Obviously, such malingering or overemphasis of illness is neither conducive to mental health nor advantageous in promoting a professional relationship of mutual trust. Thus, the medicolegal situation created by the ALI provision undermines the value of a professional relationship and is demeaning for patient and doctor alike.

Our third objection to the ALI proposal is our serious doubt whether it will, in fact, do what its proponents suggest: substantially liberalize the requirements for abortion. This, of course, depends upon the interpretation given the statute by practicing professionals and by our courts. While it is perhaps too early to tell for sure, the first months under the "liberalized" Colorado statute—patterned after the ALI proposal—indicate that rather than becoming an "abortion mill" as feared, Colorado physicians and hospitals have proceeded with caution.[50] Although there has been an increase in the number of legal abortions, it is still not sufficient to substantially lower the demand for illegal abortion. According to Dr. Edmund Overstreet, the increase that resulted from the newly adopted California version of ALI will "scarcely put a dent in the estimated 100,000 illegal abortions performed in the state each year."[51] Another unfortunate result is the possibility that the law works in an inequitable fashion with persons in the middle and upper classes who are able to take advantage of new legal provisions because of their better understanding of the law and their access to private hospitals and private physicians. One report suggested, "Some of the poor are ignorant of the law, others cannot afford an abortion . . . and in some cases hospitals have turned away clinic or Medicaid patients for lack of sufficient facilities. In California the ratio of Medi-Cal patients receiving abortion . . . is less than one-half that of private patients."[52]

Although it is hard to predict the eventual interpretation of

legal regulations by the medical establishment, it has been estimated that only 15 per cent of the cases that now end up as illegal abortions would fall into the ALI provisions.[53] Thus we may be witnessing the spectacle of reformers waging gallant battles for the ALI statute in state after state, only to find out eventually that their victories were without significant value.

Our fourth objection to the ALI approach to abortion is its unfortunate way of requiring what may amount in the pregnant woman's eyes to a public confession as a requisite to a legal abortion. Rather than protecting the confidential nature of the doctor-patient relationship, the physician's decision in a particular case may possibly be exposed to scrutiny by the state. The effect of such a procedure may well be to foster criminal abortions that remain scrupulously confidential. Indeed, results of the Scandinavian experience seem to verify this contention.[20, 54, 55]

Finally, the ALI statute also allows abortion when the child would be born with grave physical or mental defect and when the pregnancy results from rape, incest, or felonious intercourse. The former ground permits "eugenic considerations not hitherto known in American law."[2] The latter ground creates the problem of rapid determination of the factual elements of rape and incest. In both instances there are major psychological, social, genetic, and legal questions left unanswered.

### Summary and Recommendations

Many of the social, sexual, and pragmatic goals served by legal sanctions against abortion have diminished in the past decades. Their continued application no longer can be sustained by a justifiable state interest. If anything, it may be in the interest of the state to permit abortion freely as a secondary measure to limit population where contraception fails. The laws as currently enforced impose an enormous hardship on the unwilling mother, whatever her medical or psychiatric condition may be. There remains the moral issue of abortion as murder. We submit



that this is insoluble, a matter of religious philosophy and religious principle and not a matter of fact. We suggest that those who believe abortion is murder need not avail themselves of it. On the other hand, we do not believe that such conviction should limit the freedom of those not bound by identical religious conviction. Although the moral issue hangs like a threatening cloud over any open discussion of abortion, the moral issues are not all one-sided. The psychoanalyst Erik Erikson stated the other side well when he suggested that "The most deadly of all possible sins is the mutilation of a child's spirit."[56] There can be nothing more destructive to a child's spirit than being unwanted, and there are few things more disruptive to a woman's spirit than being forced without love or need into motherhood.

*It is on the basis of the foregoing discussion that we recommend that abortion, when performed by a licensed physician, be entirely removed from the domain of criminal law.*[57] *We believe that a woman should have the right to abort or not, just as she has the right to marry or not.*

We suggest that the physician who is asked to perform the abortion be expected to exercise medical judgment as he would in the case of any elective surgery.* Medical judgment will be affected by many factors. Perhaps the most controversial of these will be the length of gestation and the viability of the fetus. However, we believe that general rather than specific guidelines should be instituted. Thus, we assume that most physicians, as gestation progresses, will be increasingly reluctant to perform abortion.

As psychiatrists we would particularly emphasize the importance of the physician's exploring with the pregnant woman the basis of her motivation, so as to clarify impulsive, manipulative, or self-destructive elements in the decision to abort. The various medical judgments pertinent to abortion may, when

* The physican should have the right to refuse to perform abortion on the basis of his own moral or religious convictions. It is also essential that the operating surgeon be protected against any legal claim of the father.[58]

warranted, be arrived at with the help of consultation. We do not believe that psychiatric consultation should necessarily be routine.

We are well aware that our recommendations constitute a broad change of social policy. Given the experiences in Hungary, Sweden, and Japan,[59] we recommend that the Bureau of Census, the various population centers, and the various social and psychological research centers attend to and study the consequences of this change and, where indicated, recommend future policy changes. What we suggest is not necessarily a final step, but rather a current appropriate measure.

## NOTES AND REFERENCES


1. For a review of existing state abortion laws, see REPORT OF THE TASK FORCE ON FAMILY LAW AND POLICY TO THE CITIZEN'S ADVISORY COUNCIL ON THE STATUS OF WOMEN, Department of Labor Washington, D.C., pp. 28-29, 1968. Government Publication No. Y3.IN8/21:2F21.
2. George, B. J., Jr.: "Current Abortion Laws; Proposals and Movements for Reform," pp. 1-36; and Niswander, K.: "Medical Abortion Practices in the United States," pp. 37-59, in ABORTION AND THE LAW, D. Smith, ed., Press of Case Western Reserve University, Cleveland, 1967.
3. ALI Model Penal Code, 207.11 (2).
4. Cooke, R., et al., eds.: THE TERRIBLE CHOICE: THE ABORTION DILEMMA (For the Joseph P. Kennedy, Jr., Foundation), Bantam Books, Inc., New York, 1968, Chapter 2, "Five Case Studies," pp. 5-33. Under prevailing abortion laws in most states, none of the women in these representative case studies would be allowed to obtain a legal abortion.
5. For a reference regarding the right of women to control their own reproductive lives, see Rossi, Alice (Department of Social Relations, Johns Hopkins University): "Social Change and Abortion Law Reform," unpublished paper presented to the American Orthopsychiatric Association, Chicago, March 21, 1968. Two other sources lending emphasis to this point are Hardin, G.: "Abortion and Human Dignity," a public lecture given at the University of California at Berkeley, April 29, 1964, published by the Citizens Committee for Humane Abortion Laws, San Francisco, and the work cited above in note 1, p. 31.
6. The specific states that permit abortion only to save the life of the mother are specified and their laws discussed in note 2 above.
7. Davis, K.: "Population Policy: Will Current Programs Succeed?" *Science*, Vol. 158, No. 3802, 1967, pp. 730-739.
8. For an article expressing this view, see Curran, R.: "The Quiet Murder," *Linacre Quarterly*, November 1966, pp. 344-348.

9. Drinan, R.: "Abortion and the Law," in the work cited above in note 2, Chapter 5, p. 108 and p. 122.
10. In contrast the American Civil Liberties Union questions the constitutionality of abortion laws on the ground that such laws "are possibly violative of the First Amendment clause forbidding the establishment of religion [by the state] and guaranteeing separation of church and state." In the work cited above in note 4, p. 96.
11. Williams, G.: "History of the Law of Abortion," in THE SANCTITY OF LIFE AND THE CRIMINAL LAW, Alfred A. Knopf, Inc., New York, 1957, pp. 148-183. In this chapter Glanville Williams traces the history of the law of abortion and the underlying precepts that gave rise to past and present laws both in the United States and in England. See also Huser, R.: THE CRIME OF ABORTION IN CANON LAW, AN HISTORICAL SYNOPSIS AND COMMENTARY, The Catholic University of America Press, Washington, D.C., 1942. Religious attitudes toward abortion are of course also deeply influenced by considerations of when the soul begins as contrasted to potentially heuristic definitions of when life begins.
12. See, for example, the reports of the 16th Annual Convention of American Baptists and the 1968 General Assembly of Unitarian Universalists in the *Newsletter* of the Association for the Study of Abortion, Vol. III, No. 3, Fall 1968.
13. For example, the punishment prescribed for criminal abortion in California is a sentence of two to five years in a state prison. California Penal Code 274. For a reference that itemizes the various state penalties prescribed for criminal abortion, see Lucas, R.: "Federal Constitutional Limitations on the Enforcement and Administration of State Abortion Statutes," *North Carolina Law Review*, Vol. 46, 1967-68, p. 730. Footnotes 22, 23, 24, and 25 on pages 734 and 735 itemize the state statutes on abortion.
14. "Abortion and Human Dignity," Prof. Hardin's paper cited above in note 5.
15. With the delineation between contraception and abortion growing even more difficult, the Supreme Court ruling in *Griswold v. Connecticut*, 381 U.S. 479 (1965)—holding unconstitutional a state law against a married couple's use of contraceptives—takes on increasing significance and, in the future, may be brought to bear on the question of abortion as well as contraception. Father Drinan specifically objects to such a possible interpretation of *Griswold v. Connecticut* in his article "The Inviolability of the Right to be Born" in the work cited above in note 2, pp. 107-123.
16. ABORTION AND THE LAW, cited above in note 2, p. 56.
17. Harvard Law School Forum, 1967.



18. Hall, R.: "Therapeutic Abortion, Sterilization, and Contraception," *American Journal of Obstetrics and Gynecology*, Vol. 91, 1965, pp. 518-532.
19. Niswander, K., et al: "Changing Attitudes Toward Therapeutic Abortion," *Journal of the American Medical Association*, Vol. 196, 1966, pp. 1140-1143; and Kleegman, S.: "Planned Parenthood: Its influence on Public Health and Family Welfare," in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL, AND RELIGIOUS CONSIDERATIONS. H. Rosen, ed., Julian Press, Inc., New York, 1954, pp. 254-265.
20. The following countries under varying circumstances authorize abortion on terms substantially more liberal than those in state statutes in the United States: Bulgaria, Czechoslovakia, Denmark, England, Finland, Hungary, Iceland, Japan, Norway, Poland, Sweden, USSR, and Yugoslavia. For a review of the laws governing abortions in various countries, see Roemer, R.: "Abortion Law: The Approaches of Different Nations," *American Journal of Public Health*, Vol. 57, 1967, p. 1906.
21. The Policy Guide of the American Civil Liberties Union, revised October, 1967, takes the position that current abortion laws "deny the women in lower economic groups the equal protection of the laws guaranteed by the Fourteenth Amendment, since abortions are now freely available to the rich but forbidden to the poor." As of October, 1967, the complete ACLU position was stated as follows: "It should not be deemed a crime for a woman to seek, and for a doctor to perform, the termination of a pregnancy in accordance with generally accepted community standards of medical practice. The ACLU believes that all criminal sanctions should be removed from the area of abortion, and that the laws and standards governing this medical procedure be the same as those which govern the performance of all medical procedures. The Union views present abortion laws as unconstitutional because (1) they are unconstitutionally vague, (2) they deny to women in lower economic groups the equal protection of the laws guaranteed by the Fourteenth Amendment, since abortions are now freely available to the rich but forbidden to the poor, (3) they infringe the constitutional right to decide whether and when to have a child, as well as the marital right of privacy and the privacy of the relationship between patient and physician, (4) they impair the constitutional right of physicians to practice in accordance with their professional obligations, in that they require doctors to refrain from a medical procedure whose failure to perform would, except for the abortion laws, amount to malpractice in many cases, and (5) they deprive women of their lives and liberty, in the sense of deciding how their bodies are to be used, without due process of law."

22. Known deaths from all abortions in 1965 totalled 235 women. Of these, 106 were white and 129 were nonwhite. In the work cited above in note 4, p. 47.
23. For a moving literary description of this emotional experience, see Roth, P.: LETTING GO, Random House, Inc., New York, 1962.
24. Sloane, R. B.: "The Unwanted Pregnancy," *New England Journal of Medicine*, Vol. 280, 1969, p. 1206.
25. Deutsch, Helene: PSYCHOLOGY OF WOMEN: Vol. 2, MOTHERHOOD, Research Books Ltd., London, 1947, p. 165.
26. Forssman, H., and Thuwe, I.: "One Hundred and Twenty Children Born After Application for Therapeutic Abortion Refused," *Acta Psychiatrica Scandinavica*, Vol. 42, 1966, pp. 71-78. In an earlier paper Caplan reported that special problems are apt to develop between mother and child when an unsuccessful attempt at abortion has been made. Caplan, G.: "The Disturbance of the Mother-Child Relationship by Unsuccessful Attempts at Abortion," *Mental Hygiene*, Vol. 38, 1954, pp. 67-80.
27. Bowlby, J.: MATERNAL DEPRIVATION, Schocken Books, Inc., New York, 1966.
28. Fleck, S., M.D., in an unpublished paper entitled "Some Psychiatric Aspects of Abortion," presented to the Connecticut Medical Society, May 2, 1968, stated, "Preventive psychiatry's single most effective tool is the prevention of unwanted offspring. . . . "
29. "Abortion and Human Dignity," the paper cited above in note 5. Hardin's observation takes on special significance in light of the increasing ability of doctors to diagnose serious genetic defects in the third and fourth months of pregnancy. For an example of how such a diagnosis led to a therapeutic abortion of a fetus certain to develop into a child requiring life-long institutional care, and allowed the mother to deliver a normal child in a subsequent pregnancy, see the *Boston Globe*, October 16, 1968, p. 3.
30. For a description of this procedure, see Vladov, E.: "The Vacuum Aspiration Method for Interruption of Early Pregnancy," *Obstetrics and Gynecology*, Vol. 99, 1967, p. 202. The study offers a favorable comparison between the vacuum aspiration method and the conventional use of curettage. Comparisons were made as to loss of blood, early complications, and late complications. In "Abortion and Human Dignity," cited above in note 5, Hardin points out that in Hungary, where legal abortion is readily available (and where the vacuum technique has been introduced), the death rate in more than a quarter of a million cases is less than 6 per 100,000. This constrasts with 17 deaths per 100,000 in the United States resulting from the removal of tonsils and adenoids, and with 24 deaths per 100,000 in the United States resulting from childbirth and its complications.



31. Romm, May: "Psychoanalytic Considerations in Therapeutic Abortion," in THERAPEUTIC ABORTION, cited above in note 19.
32. Simon, N., and Senturia, A.: "Psychiatric Sequelae of Abortion: Review of Literature 1935-64," *Archives of General Psychiatry*, Vol. 15, 1966, p. 378.
33. Taussig, F. J.: ABORTION, SPONTANEOUS AND INDUCED: MEDICAL AND SOCIAL ASPECTS, C. V. Mosby Co., St. Louis, 1936.
34. Malmfors, K.: "Problem of Women Seeking Abortion," in ABORTION IN THE UNITED STATES, M. S. Calderone, ed., Harper & Bros., New York, 1958, pp. 133-136.
35. Brekke, B.: "Other Aspects of Abortion Problems," in ABORTION IN THE UNITED STATES, pp. 133-136.
36. Simon, N.; Senturia, A.; and Rothman, D.: "Psychiatric Illness Following Therapeutic Abortion," *American Journal of Psychiatry*, Vol. 124, 1967, p. 59.
37. Peck, A., and Marcus, H.: "Psychiatric Sequelae of Therapeutic Interruption of Pregnancy," *Journal of Nervous and Mental Disease*, Vol. 143, 1966, pp. 417-425. See also Kummer, J.: "Post-abortion Psychiatric Illness—A Myth?" *American Journal of Psychiatry*, Vol. 119, 1963, pp. 980-993; Ekblad, M.: "Induced Abortion on Psychiatric Grounds. A Follow-up Study of 479 Women," *Acta Psychiatrica et Neurologica Scandinavica*, Supp. 99, 1955; and Dr. Fleck's paper cited above in note 28.
38. Of the estimated three million illegitimate children under 18 years of age in the United States in December, 1961, 31 per cent had been adopted. The proportions are strikingly different by race, however; 70 per cent of the white and only 5 per cent of the nonwhite illegitimate children under 18 years of age were adopted. Foote, C.; Levy, R. J.; and Sander, F. E. A.: CASES AND MATERIALS ON FAMILY LAW, Little, Brown & Co., Boston, 1966, p. 88.
39. On page 8 of "The Right of the Fetus to be Born," an unpublished paper prepared for the International Conference on Abortion, Washington, D.C., September 6-8, 1967, Father Drinan takes the position that the ALI proposal "seeks to evade the basic question of whether the fetus has a right to be born." While opposed to abortion except where it is necessary to save the life of the mother, he notes that an absence of law with respect to abortion "has at least the merit of not involving the law and society in the business of selecting those persons whose lives may be legally terminated. A system of permitting abortion on request has the undeniable virtue of neutralizing the law so that, while the law does not forbid abortion, it does not on the other hand sanction it,—even on a presumably restricted basis." See also Lynch, J., "A Report: Legalized Abortion," and Camardese, N., Editorial: "Man Plays God." *Linacre Quarterly*, Vol. 35, No. I, 1968, pp. 39-41 and p. 42, respectively.

40. Louisell, D. W.: "Abortion, the Practice of Medicine and Due Process of Law," *UCLA Law Review*, Vol. 16, No. 2, 1969, pp. 233-254.
41. Russell, K.: "Changing Indications for Therapeutic Abortion: Twenty Years' Experience at Los Angeles County Hospital," *Journal of the American Medical Association*, Vol. 151, 1953, p. 108. Packer and Gampell: "Therapeutic Abortion: A Problem in Law and Medicine," *Stanford Law Review*, Vol. 11, 1959, pp. 417-455.
42. The criteria presented here were selected from: "Indications for Termination of Pregnancy," *British Medical Journal*, Vol. 1, 1968, p. 171.
43. Tredgold, R. F.: "Psychiatric Indications for Termination of Pregnancy," *Lancet*, Vol. 2, 1964, pp. 1251-1254.
44. Although the risk of suicide is one of the most common reasons for allowing abortion, Sloane's review of published data suggests that actual suicide in these circumstances is rare. Cf.: Höök, K.: "Refused Abortion: Follow-up Study of 294 Women Whose Applications Were Refused by National Board of Health in Sweden," *Acta Psychiatrica Scandinavica*, Vol. 39 (Supp. 168), 1963, pp. 1-156; Ekblad, M.: "Induced Abortion on Psychiatric Grounds: Follow-up Study of 479 Women," *Acta Psychiatrica et Neurologica Scandinavica*, Supp. 99, 1955, pp. 1-238; Anderson, E. W.: "Psychiatric Indications for Termination of Pregnancy," *Journal of Psychosomatic Research*, Vol. 10, 1966, pp. 127-134; Lindberg, B. J.: "Vad gör den abortsökande kvinnan. när psykiatern sagt nej?" *Svenska Läkartidningen*, Vol. 45, 1948, pp. 1382-1395; Dahlgren, K. G.: ON SUICIDE AND ATTEMPTED SUICIDE: A PSYCHIATRIC AND STATISTICAL INVESTIGATION, Universitats Bokhander, Lund, Sweden, 1945.
45. Sim, M.: "Abortion and the Psychiatrist," *British Medical Journal*, Vol. 2, 1963, p. 1455.
46. Sim, M.: Correspondence, *British Medical Journal*, Vol. 2, 1963, p. 1062.
47. Aarons, Z.: "Therapeutic Abortion and the Psychiatrist," *American Journal of Psychiatry*, Vol. 124, 1967, p. 745.
48. In the work cited above in note 4 on p. 78.
49. In the place cited above in note 46.
50. Heller, A., and Whittington, H. G.: "The Colorado Story: Denver General Hospital Experience with the Change in the Law on Therapeutic Abortions," *American Journal of Psychiatry*, Vol. 125, 1968, pp. 809-816.
51. *New York Times*, November 24, 1968.
52. *Medical World News*, May 23, 1963, p. 39.



53. In the work cited above in note 1 on p. 29.
54. Smith, D.: "In Sweden, the advent of liberal abortion laws was accompanied by a decline in criminal abortion only to be followed by a resurgence due to the time and bother of justifying an abortion before a reviewing committee." In the work cited above in note 2, chapter 3, p. 70.
55. Huldt, L.: "Outcome of Pregnancy When Legal Abortion is Readily Available," *Lancet*, Vol. 1, 1968, p. 467.
56. Erikson, E.: THE YOUNG MAN LUTHER, W. W. Norton & Co., New York, 1958, p. 70, in Garrett Hardin: "Blueprints, D.N.A. and Abortion: A Scientific and Ethical Analysis," *Medical Opinion and Review*, 1967.
57. This is a position taken by a number of groups, most notably in the Task Force Report cited above in note 1.
58. It has been argued that a policy that places primary emphasis on the woman's right to control her own reproductive life neglects the right of the husband to become a father (see dissenting opinion in the Task Force Report cited above in note 1). In fact, a recent California decision raised the possibility that the husband has a legal cause of action and that he can sue for damages the doctor who aborts his wife over his (the husband's) wishes ("The Expectant Father Protected: Tort Action Allowed Against Abortionist," *Stanford Law Review*, Vol. 14, 1962, p. 901). Such a legal
59. Cf. References 24 and 55.

## Acknowledgments

The program of the Group for the Advancement of Psychiatry, a non-profit, tax-exempt organization, is made possible largely through the voluntary contributions and efforts of its members. For their financial assistance during the past fiscal year, in helping it to fulfill its aims, GAP is grateful to the following foundations and organizations:

Sponsors

THE COMMONWEALTH FUND
THE DIVISION FUND
MAURICE FALK MEDICAL FUND
THE GRANT FOUNDATION
THE GROVE FOUNDATION
THE HOLZHEIMER FUND
ITTLESON FAMILY FOUNDATION
THE OLIN FOUNDATION
OPPENHEIMER & CO. FOUNDATION, INC.
A. H. ROBINS COMPANY
ROCHE LABORATORIES
SANDOZ PHARMACEUTICALS
THE MURRAY L. SILBERSTEIN FUND
SQUIBB INSTITUTE FOR MEDICAL RESEARCH
SMITH KLINE & FRENCH FOUNDATION
THE UPJOHN COMPANY
WALLACE PHARMACEUTICALS
WYETH LABORATORIES

Donors

VIRGINIA & NATHAN BEDERMAN FOUNDATION
THE GRALNICK FOUNDATION
THE FOREST HOSPITAL FOUNDATION



## Publications of the Group for the Advancement of Psychiatry

Because readers of this publication may not be aware of GAP titles on related subjects, a selected listing is given below:

| *Number* | *Title* | *Price* |
|---|---|---|
| 27A | INTEGRATION AND CONFLICT IN FAMILY BEHAVIOR—Aug. 1954; reissued June 1968 | $1.50 |
| 44 | CONFIDENTIALITY AND PRIVILEGED COMMUNICATION IN THE PRACTICE OF PSYCHIATRY—June 1960 | .75 |
| 49 | REPORTS IN PSYCHOTHERAPY: INITIAL INTERVIEWS—June 1961 | .75 |
| 58 | MEDICAL PRACTICE AND PSYCHIATRY: THE IMPACT OF CHANGING DEMANDS—Oct. 1964 | .75 |
| 61 | LAWS GOVERNING HOSPITALIZATION OF THE MENTALLY ILL—May 1966 | .50 |
| 63 | PSYCHIATRIC RESEARCH AND THE ASSESSMENT OF CHANGE—Nov. 1966 | 2.50 |
| 71 | ON PSYCHOTHERAPY AND CASEWORK (A Position Statement)—March 1969 | 1.00 |
| 74 | THE PSYCHIATRIST AND PUBLIC ISSUES—Oct. 1969 | 1.00 |
| 76 | THE CASE HISTORY METHOD IN THE STUDY OF FAMILY PROCESS—March 1970 | 4.00 |
| 78 | THE FIELD OF FAMILY THERAPY—March 1970 | 3.00 |

*Orders amounting to less than $5.00 must be accompanied by remittance. All prices are subject to change without notice.*

*GAP publications may be ordered on a subscription basis. The current subscription cycle comprising the Volume 7 Series covers the period from*

*July 1, 1968 to June 30, 1971. The subscription fee is $12.00 U.S.A. and $13.00 Canadian and other foreign, payable in U.S. currency.*

*Bound volumes of GAP publications issued since 1947 are also available. They include GAP titles no longer in print that are unavailable in any other form.*

*Please send your order and remittance to: Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, New York 10016.*

---

*This publication was produced for the Group for the Advancement of Psychiatry by the Mental Health Materials Center, Inc., New York.*