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# Abortion on Request: The Psychiatric Implications

*Richard A. Schwartz*

## I. INTRODUCTION

**A**LTHOUGH THE PRACTICE of abortion has been illegal in most states until recently, it has been an "open secret" that a woman can obtain a safe abortion in a licensed hospital if she can find a psychiatrist who will say she might commit suicide if her pregnancy is not terminated.

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Consequently, most practicing psychiatrists have often been consulted by pregnant women seeking abortions, which has provided the psychiatric profession with a unique opportunity to become familiar with the kinds of problems that lead

women to the decision to abort and to observe women's emotional reactions before and after abortions. To the psychiatrist, then, abortion is not merely an abstract moral and legal question, but an intensely emotional experience concerning individual women and their families. Because of this direct personal experience, it is not surprising that psychiatrists — both individually through speeches and writings<sup>1</sup> and collectively through their professional organizations<sup>2</sup>

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<sup>1</sup> A selective list of articles and books representing the many comprehensive discussions of the abortion problem by psychiatrists includes: ABORTION: CHANGING VIEWS AND PRACTICE (R. Sloane ed. 1970); THERAPEUTIC ABORTION (H. Rosen ed. 1954); Aarons, *Therapeutic Abortion and the Psychiatrist*, 124 AM. J. PSYCHIATRY 745 (1957); Fleck, *Some Psychiatric Aspects of Abortion*, 151 J. NERVOUS & MENTAL DISEASE 42 (1970); Kummer, *Post-Abortion Psychiatric Illness — A Myth?*, 119 AM. J. PSYCHIATRY 980 (1963); Lebensohn, *Abortion, Psychiatry, and the Quality of Life*, 128 AM. J. PSYCHIATRY 946 (1972); Levene & Rigney, *Law, Preventive Psychiatry, and Therapeutic Abortion*, 151 J. NERVOUS & MENTAL DISEASE 51 (1970); Peck & Marcus, *Psychiatric Sequelae of Therapeutic Interruption of Pregnancy*, 143 J. NERVOUS & MENTAL DISEASE 417 (1966); Rosen, *Psychiatric Implications of Abortion: A Case Study in Social Hypocrisy*, 17 W. RES. L. REV. 435 (1965); Schwartz, *Psychiatry and the Abortion Laws: An Overview*, 9 COMPREHENSIVE PSYCHIATRY 99 (1968); Schwartz, *The Abortion Laws: A Severe Case of Resistance to Change*, 67 OHIO ST. MED. J. 33 (1971); Simon, Senturia & Rothman, *Psychiatric Illness Following Therapeutic Abortion*, 124 AM. J. PSYCHIATRY 59 (1967); Sloan, *The Unwanted Pregnancy*, 280 N. ENGLAND J. MED. 1206 (1969); White, *Induced Abortions: A Survey of Their Psychiatric Implications, Complications, & Indications*, 24 TEXAS REP. OF BIOLOGY & MED. 531 (1966).

— have been active participants in the public debate on abortion that has raged throughout the country for the past decade.

Generally, psychiatrists have occupied a liberal position in the debate, favoring repeal of the traditional, restrictive abortion laws. And this position is not limited to the leaders or a few vocal members, for the rank and file of the profession have tended to the liberal position as well.<sup>2</sup> There are a number of reasons why psychiatric opinion has been so heavily in favor of legalization of abortion. For one, it is a very convincing educational experience to talk with women who have become pregnant accidentally, do not want a child, and who are determined to have an abortion by one means or another. After several such interviews, one is hard pressed to maintain the view that the abortion decision should be made by anybody other than the pregnant woman. The decision is certainly much too personal and private to be decided by the state. Undoubtedly, another important factor is that only a minority of psychiatrists are members of fundamentalist religions, whose members comprise most of the opposition to legalized abortion because of their belief that abortion is the taking of human life.<sup>4</sup>

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<sup>2</sup>The American Psychiatric Association, the official voice of organized psychiatry, adopted the following resolution in 1969:

A decision to perform an abortion should be regarded as strictly a medical decision and a medical responsibility. It should be removed entirely from the jurisdiction of criminal law. Criminal penalties should be reserved for persons who perform abortions without medical license or qualification to do so. A medical decision to perform an abortion is based on the careful and informed judgments of the physician and the patient. Among other factors to be considered in arriving at the decision is the motivation of the patient. Often psychiatric consultation can help clarify motivational problems and thereby contribute to the patient's welfare. Position Statement on Abortion, *reprinted in* 126 AM. J. PSYCHIATRY 1554 (1970).

A similar policy statement was adopted in the same year by the Group for Advancement of Psychiatry, one of the largest and most prestigious psychiatric organizations. Their statement specifically said: "[W]e recommend that abortion when performed by a licensed physician be entirely removed from the domain of criminal law. We believe that a woman should have the right to abort or not, just as she has the right to marry or not." GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, THE RIGHT TO ABORTION: A PSYCHIATRIC VIEW (Vol. 7, No. 75), 219 (1969).

<sup>3</sup>The largest survey taken (2041 psychiatrists were contacted) to determine the views of psychiatrists on abortion showed overwhelming support for liberalized abortion laws. To the question, "Should abortion be available to any woman capable of giving legal consent upon her own request to a competent physician?" 79.5 percent answered in the affirmative (71.7 percent without qualification, and 7.8 percent with qualification). Compared with physicians in other specialties who were also surveyed, psychiatrists had the highest percentages favoring abortion on request. The percentage of all physicians favoring abortion on request was 62.8 percent (51.0 percent without qualification and 11.8 percent with qualification). MODERN MED., Nov. 3, 1969, at 19.

<sup>4</sup>See Duffy, *The Case Against Abortion: A Plea for the Unborn Child*, 56 WOMEN

In addition to these two general reasons for favoring legalization of abortion, there are four additional considerations of a more specifically psychiatric nature that have contributed to proabortion attitudes among psychiatrists. First, the existing practice of permitting so-called therapeutic abortions on psychiatric grounds for a small group of middle-class women is considered hypocritical and unjust. Secondly, follow-up studies have shown abortions to have few harmful psychiatric after-effects. Thirdly, a social policy forbidding abortion and, in effect, forcing women to bear unwanted children is harmful to the mental health of many women, as well as the members of their families. And finally, unwanted children (the number of which could be minimized by liberalizing abortion laws) are likely to receive inadequate care during their early, formative years and, as a result, often become vulnerable to psychiatric disorders. This article will closely examine each of these four reasons while presenting its thesis that abortion laws should be liberalized.

## II. THERAPEUTIC ABORTIONS ON PSYCHIATRIC GROUNDS

Until 1967, when Colorado became the first of 16 states and the District of Columbia<sup>5</sup> to liberalize its abortion laws, virtually all states had laws which forbade abortion unless "necessary to preserve the woman's life."<sup>6</sup> As was commonly known, however, these re-

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L.J. 86 (1970); *Abortion Legislation and the Establishment Clause*, 15 CATHOLIC LAWYER 108, 114 (1969).

<sup>5</sup> Prior to 1967 only three states amended their statutes to provide for abortion on additional grounds: Alabama in 1951, ALA. CODE tit. 14, § 9 (1959) (gravely impair physical health); New Hampshire in 1955, N.H. REV. STAT. ANN. § 585.13 (1955) (malformation of the fetus); Mississippi in 1966, MISS. CODE ANN. § 2223 (Supp. 1971) (pregnancy as a result of rape). The liberalizations since 1967 are: ARK. STAT. ANN. § 41-304 (Supp. 1969); ALASKA STAT. § 11.15.060 (1970); CAL. HEALTH & SAFETY CODE § 25951 (Supp. 1971); COLO. REV. STAT. ANN. § 40-6-101 (1971); DEL. CODE ANN. tit. 24, § 1790 (Supp. 1970); D.C. CODE ANN. § 22-201 (1967); GA. CODE ANN. § 26-1202 (Rev. 1971) [portion of statute allowing abortion only when necessary to preserve life or health held unconstitutional in *Doe v. Bolton*, 319 F. Supp. 1048 (N.D. Ga. 1970) (per curiam), *jurisdiction postponed*, 402 U.S. 941 (1971)]; HAWAII REV. LAWS § 453-16 (Supp. 1971); KAN. GEN. STAT. ANN. § 21-3407 (Supp. 1971) [*Poe v. Menghini*, 40 U.S.L.W. 2666 (D. Kan. Mar. 10, 1972) (requirement that all abortions be approved by three physicians and performed in an approved hospital held unconstitutional)]; MD. ANN. CODE art. 43, § 137 (1971); N.M. STAT. ANN. §§ 40A-5-1 (Supp. 1971); N.Y. PENAL LAW § 125.05 (Supp. 1971); N.C. GEN. STAT. § 14-45.1 (Supp. 1971); ORE. REV. STAT. § 435.415 (1971); S.C. CODE ANN. § 16-87 (Supp. 1971); VA. CODE ANN. § 18.1-62.1 (Supp. 1971); WASH. REV. CODE § 9.02.010 (1961). See note 14 *infra* for a list of those states which follow the Model Penal Code.

<sup>6</sup> For a comprehensive review of the abortion laws of the various states, see George, *The Evolving Law of Abortion*, 23 CASE W. RES. L. REV. 708 (1972).

strictive laws did not deter large numbers of women from obtaining illegal abortions. Indeed, women have always obtained abortions and presumably always will, regardless of prohibitive laws. In addition to these illegal abortions, many upper middle-class women have been able to obtain so-called therapeutic abortions from their private gynecologists under ideal conditions and in some of the best hospitals in the United States. During the years 1963 through 1965, for example, there were an estimated 8000 therapeutic abortions performed each year, or two abortions per 1000 births.<sup>7</sup>

Since medical advances have made it possible for women with almost any kind of physical illness to survive pregnancy and childbirth, the only way that abortions can be legally justified as "necessary to preserve life" is on psychiatric grounds — *i.e.*, if the patient is judged to be in danger of committing suicide. The practice of therapeutic, or more precisely psychiatric, abortions has always been controversial. First of all, it is impossible on any medical or scientific grounds to establish agreed-upon indications for psychiatric abortions. A woman who wants an abortion, and who knows that the only way she can obtain one is to persuade a psychiatrist that she will commit suicide, has a strong incentive to convince herself that she is deeply depressed or, at least, to act depressed. In such situations, psychiatrists have no reliable way of judging the precise degree of suicidal risk.

Even if they could determine with exactitude the likelihood of suicide, psychiatrists would still be unable to decide whether a given woman "deserved" an abortion because of the vagueness of the requirement, "necessary to preserve the woman's life." There are no guidelines indicating whether the risk of suicide has to be 100, 50, or one percent in order for an abortion to be justified under the law. Nor is it clear whether the woman has to have a past history of suicidal tendencies or mental illness in order that the abortion be considered life-saving, or whether the woman has to be perfectly well adjusted and symptom-free prior to the onset of pregnancy. The laws offer no clarification of these points, which is one of the reasons why some courts have declared them to be unconstitutionally vague.<sup>8</sup>

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<sup>7</sup> Tietze & Lewit, *Abortion*, 220 SCIENTIFIC AM. 21, 23 (1969). The definitions of "therapeutic abortion" are various. Here, the term is taken to include those abortions which are performed for one or more of the medical or psychiatric indications allowed by a given state's law.

<sup>8</sup> In *People v. Belous*, 71 Cal. 2d 954, 458 P.2d 194, 80 Cal. Rptr. 354 (1969), *cert. denied*, 397 U.S. 915 (1970), the court concluded that section 274 of the California

In the absence of definite criteria for determining whether a given pregnancy is a threat to a woman's life, psychiatrists are obliged to fall back on purely subjective criteria in making their decision. In deciding whether or not to approve a given abortion, psychiatrists have little more to guide them than their own personal opinions about whether abortions are good or bad for women, or for society as a whole. In their practices, psychiatrists handle this predicament in one of four general ways. One group of psychiatrists refuses to have anything to do with abortion evaluations as a matter of principle. They feel that psychiatric abortions are hypocritical, that society should not pass laws forbidding abortion and then allow circumvention of the laws because a woman is emotionally upset and threatening suicide. Society, they believe, should decide whether or not to permit abortions, rather than evade this decision by delegating it to the psychiatrist, who is without special competence to determine the question.

This same group of psychiatrists also objects to the gross unfairness that results from the practice of psychiatric abortions, which favor the histrionic, the emotionally unstable, and the deceitful woman, permitting her to abort while denying abortion to women who are truthful and emotionally stable. Psychiatric abortions also favor the rich, who can afford private psychiatric fees, over the poor who cannot. Although poor people have access to psychiatrists in public clinics, these clinics are dependent on public funds appropriated by elected officials and are usually unwilling to risk the disapproval of those officials by sanctioning abortions for their patients. In reality, whether a woman will be granted an abortion depends far less on the state of her health than upon the state of her pocketbook.

Many in this first group of psychiatrists further argue that those psychiatrists who participate in psychiatric abortions have a harmful social impact over the long term because they abate pressures that might lead to liberalization of the abortion laws. By enabling the most influential segment of the population to arrange for psychiatric abortions, psychiatrists remove whatever incentive this group might have to support reform of the laws. These psychiatrists are also

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Penal Code, which provides that a physician can administer an abortion only if he "deems it necessary" to save the patient's life, "is not susceptible of a construction that does not violate legislative intent and that is sufficiently certain to satisfy due process requirements without improperly infringing on fundamental [federal and California] constitutional rights." Cal. 2d at 960, 458 P.2d at 197, 80 Cal. Rptr. at 357.

concerned that the image of the psychiatric profession is tarnished by providing psychiatric "excuses" for rich women to evade the law.<sup>9</sup>

A second group of psychiatrists also refuses to participate in psychiatric abortions, but on moral or religious grounds. This group believes that abortion is morally wrong, or even murder, and believes that no psychiatric illness, however serious, can justify an abortion. In cases of women genuinely threatening suicide, these psychiatrists propose commitment to a psychiatric hospital, administration of antidepressant drugs, or electroshock treatment.<sup>10</sup>

A third group of psychiatrists, while agreeing that psychiatric abortions are hypocritical and unfair, believes that it would be unethical to refuse to consult with women who are emotionally upset and who request help. Although they may be reluctant or unenthusiastic, these psychiatrists will agree to consult with abortion-seeking women and will conscientiously try to determine if the degree of suicidal risk is substantial. If so, they will authorize the abortion.

The fourth group of psychiatrists strongly feels that most women who want abortions will benefit from them and should be permitted to obtain them. Moreover, they interpret their highest obligation as physicians, above all other considerations, to be the protection of their patients' health and well-being. In order to help women obtain abortions, this group is willing to authorize abortions in cases where they believe the risk of suicide is minimal or nonexistent because they consider that the slight deceit that is necessary is preferable to driving a desperate woman into the hands of a criminal abortionist or forcing her to bear an unwanted child. These psychiatrists, although acknowledging that their policies might help perpetuate unjust laws, believe it is even more beneficial to encourage the widespread practice of therapeutic abortions in order to help educate the public to the idea that abortions should be regarded as an accepted part of medical practice.

Thus, whether a patient is provided with an opportunity for a therapeutic abortion depends not only upon her pocketbook and whether she is living in an area where private psychiatrists are available, but also upon the philosophical point of view of the psychiatrist whom she happens to consult. If she happens to contact a

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<sup>9</sup> See Halleck, *Excuse Makers to the Elite: Psychiatrists as Social Movers*, MED. OPINION Dec. 1971, at 48.

<sup>10</sup> See Ayd, *Abortion: The Catholic Viewpoint*, in ABORTION: CHANGING VIEWS AND PRACTICE 48 (R. Sloane ed. 1970); Wilson, *The Abortion Problem in the General Hospital*, in THERAPEUTIC ABORTION 189 (H. Rosen ed. 1954).

psychiatrist from group one or two, she will be refused permission for a legal abortion. If she consults one from group three, she has a fair chance of obtaining the requisite approval, and if she is lucky enough to happen upon one from group four, she is virtually assured a safe hospital abortion.<sup>11</sup>

The situation described above pertains to those 26 states where abortion is prohibited "unless necessary to preserve the life of the woman."<sup>12</sup> Since 1967, the Model Penal Code<sup>13</sup> of the American Law Institute (ALI) has been adopted by 13 states<sup>14</sup> which now per-

<sup>11</sup> It remains for the courts to decide whether this state of affairs is consistent with the equal protection clause of the 14th amendment. Cf. Lucas, *Federal Constitutional Limitations on the Enforcement and Administration of State Abortion Statutes*, 46 N.C. L. REV. 730, 769-75 (1968), for a discussion of the equal protection argument in terms of income and residential requirements.

<sup>12</sup> The respective statutes of these states are: ARIZ. REV. STAT. ANN. § 13-211 (1956); CONN. GEN. STAT. ANN. § 53-29 (1958) [held unconstitutional in *Abele v. Markel*, \_\_\_ F. Supp. \_\_\_ (D. Conn. 1972)]; IDAHO CODE ANN. § 18-1506 (Supp. 1971); ILL. ANN. STAT. ch. 38, § 23-1 (1970) [held unconstitutional in *Doe v. Scott*, 321 F. Supp. 1385 (N.D. Ill. 1971), *appeals docketed sub. noms.* *Hanrahan v. Doe and Heffernen v. Poe*, 39 U.S.L.W. 3438 (U.S. Mar. 29, 1971)]; IND. ANN. STAT. § 10-105 (1956); IOWA CODE ANN. § 701.1 (1950); KY. REV. STAT. § 436.020 (1969); ME. REV. STAT. ANN. ch. 17, § 51 (1965); MICH. COMP. LAWS ANN. § 750.14 (1968); MINN. STAT. ANN. § 617.18 (1964); MO. ANN. STAT. § 559.100 (1953); MONT. REV. CODE ANN. § 94-401 (1969); NEB. REV. STAT. § 28-404 (1965); NEV. REV. STAT. § 201-120 (1967); N.D. CENT. CODE § 12-25-01 (1960); OHIO REV. CODE § 2901.15 (1953); OKLA. STAT. ANN. tit. 21, § 861 (Supp. 1971); R.I. GEN. LAWS ANN. § 11-3-1 (1970); S.D. COMP. LAWS ANN. § 22-17-1 (1967); TENN. CODE ANN. § 39-301 (1955); TEX. PEN. CODE ANN. art. 1191 (1961) [held unconstitutional in *Roe v. Wade*, 214 F. Supp. 1217 (N.D. Texas, 1970), *jurisdiction postponed*, 402 U.S. 941 (1971)]; UTAH. CODE ANN. § 76-2-1 (1953); VT. STAT. ANN. tit. 13, § 101 (1958) [held unconstitutional in *Beecham v. Leahy*, \_\_\_ Vt. \_\_\_, 287 A.2d 836 (1972)]; W. VA. CODE ANN. § 61-2-8 (1966); WIS. STAT. ANN. § 940.04 (1958) [held unconstitutional in *Babbitt v. McCann*, 310 F. Supp. 293, 320 F. Supp. 219 (E.D. Wis. 1970), *vacated and remanded*, 402 U.S. 903 (1971)]; WYO. STAT. ANN. § 6-77 (1959).

<sup>13</sup> MODEL PENAL CODE § 230.3 (Proposed Official Draft, 1956). The most pertinent part reads:

A licensed physician is justified in terminating a pregnancy if 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 that the pregnancy resulted from rape, incest, or other felonious intercourse. All illicit intercourse with a girl below the age of 16 shall be deemed felonious for purposes of this subsection. Justifiable abortions shall be performed only in a licensed hospital except in case of emergency when hospital facilities are unavailable. *Id.* § 203.3(2).

<sup>14</sup> The respective statutes of these states are: ARK. STAT. ANN. § 41-304 (Supp. 1969); CAL. HEALTH & SAFETY CODE § 25951 (Supp. 1971); COLO. REV. STAT. ANN. § 40-6-101 (1971); DEL. CODE ANN. tit. 24, § 1790 (Supp. 1970); FLA. SESS. LAWS ch. 72-196 (West 1972); GA. CODE ANN. § 26-1202 (Rev. 1971) [portion of statute allowing abortion only when necessary to preserve life or health held unconstitutional in *Doe v. Bolton*, 319 F. Supp. 1048 (N.D. Ga. 1970) (per curiam), *jurisdiction postponed*, 402 U.S. 941 (1971)]; KAN. GEN. STAT. ANN. § 21-3407 (Supp. 1971) [*Poe v. Menghini*, 40 U.S.L.W. 2666 (D. Kan. Mar. 10, 1972), held unconsti-



mit abortion to protect the woman's physical and mental health as well as her life. Most of these "reforms" have in many ways perpetuated the difficulties that existed previously. Because there are few medical illnesses that are genuinely made worse by pregnancy, most abortions are still granted on mental health grounds under the new laws. Also, a psychiatric abortion under new laws is a matter of whether the pregnancy will impair the woman's mental health, rather than of determining suicidal risk, and the standards for judging this question are even more nebulous than with respect to the older suicide standard. And finally, all the inequities that existed under the previous laws have been perpetuated. The woman who cannot afford a private psychiatrist will still have difficulty in obtaining a therapeutic abortion via the public psychiatric clinics, and even the woman who can afford a private psychiatrist must still face the problem of finding one with the "right" philosophical persuasion.

Since 1970, when the New York law was amended<sup>15</sup> to permit abortion upon request, many of these problems have been solved at least in that state. New York State now allows a woman to obtain a safe, legal abortion for approximately one to two hundred dollars. She no longer has to go through the humiliating charade of trying to convince psychiatrists that she is mentally ill or suicidal. And the psychiatrists in New York are no longer faced with the painful dilemma of deciding whether to allow themselves to be "used" by society to make decisions which properly should remain in the hands of the woman, her husband, and their physician. With the incidence of mental illness, alcoholism, and drug abuse on the rise, most psychiatrists believe that their time would be better spent caring for patients suffering with these more serious problems than by participating in the hypocritical, legally questionable, and ethically doubtful practice of certifying women for so-called therapeutic abortions.

### III. ARE ABORTIONS EMOTIONALLY HARMFUL?

A question that is frequently raised by women contemplating abortion is, "How will this experience affect me emotionally?" It is

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tutional the requirement that all abortions be approved by three physicians and performed in an approved hospital]; MD. ANN. CODE art. 43, § 137 (1971); N.M. STAT. ANN. § 40A-5-1 (Supp. 1971); N.C. GEN. STAT. § 14-45.1 (Supp. 1971); ORE. REV. STAT. § 435.415 (1971); S.C. CODE ANN. § 16-87 (Supp. 1971); VA. CODE ANN. § 18.1-62 (Supp. 1971).

<sup>15</sup> N.Y. PENAL LAW § 125.5 (McKinney Supp. 1971).

a widespread belief in our culture that women suffer guilt reactions or depression following abortion, either immediately after the procedure or at a later point in life (particularly menopause). Dr. Galdston, among others, contends that:

[I]f and when a so-called adult woman, a responsible female, seeks an abortion, unless the warrant for it is overwhelming — as say in the case of rape or incest — we are in effect confronted with a sick person and sick situation. Furthermore, and I want strongly to underscore this point, neither the given person nor the given situation is likely to be remedied by the abortion, *qua abortion*. It is of course true that both the person and the situation may be relieved and somewhat ameliorated by the abortion . . . but I would like to go on record that in numerous instances both the individual and the situation are actually aggravated rather than remedied by the abortion. Bad as the situation was initially it not infrequently becomes worse after the abortion has taken place. . . . Drawing upon my experience I would summate the major psychological effects in three terms: frustration, hostility, and guilt.<sup>16</sup>

Until recent years, psychiatric knowledge concerning the woman's psychological reaction was limited to clinical impressions derived from experience with patients seen in psychiatric practice. In the past 15 years, however, numerous systematic follow-up studies have been carried out in Europe and the United States. By and large, these studies strongly suggest that, contrary to folklore, serious psychiatric sequelae to abortion are relatively rare. Most women tolerate the procedure quite well from the emotional standpoint.

The table below summarizes the findings of 17 follow-up studies reported in the journals. At the outset, it should be noted that

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<sup>16</sup> Statement made by Dr. Iago Galdstone at an abortion conference sponsored by the Planned Parenthood Federation of America, *reprinted in* ABORTION IN THE UNITED STATES 119-20 (M. Calderone ed. 1959) [hereinafter cited as ABORTION]. This belief has been shared by other prominent psychiatrists such as Doctors Bolter and Wilson:

Despite protests to the contrary, we know that women's main role here on Earth is to conceive, deliver, and raise children. . . . When this function is interfered with, we see all sorts of emotional disorders and certainly the climax of these disorders is reached at the menopause when women recognize that they no longer can reproduce their kind and interpret the menopause as the end of life rather than the change of life. . . . The author has never seen a patient who has not had guilt feelings about a previous therapeutic abortion or illegal abortion. Bolter, *The Psychiatrist's Role in Therapeutic Abortion: The Unwitting Accomplice*, 119 AM. J. PSYCHIATRY 312, 314-15 (1962).

Many mothers who during the first weeks felt terrified at the thought of having a child, later bless the doctor who refused to allow them to proceed with their plans for abortion. It is also true that the women who experience an abortion, whether therapeutic or criminal, is traumatized by the act to such a degree that the memory becomes a potent factor in her future behavior pattern. Wilson, *supra* note 10, at 196.

there are great differences in methodology and terminology among this group of studies. In the European studies, for example, it is often hard for the American psychiatrist to tell exactly what factors are being measured and by what criteria. Consequently, it is difficult to compare these studies with one another. But despite these problems, the following conclusions can be made: First, psychiatric problems attributable to abortions were found to be rare, occurring in no more than one to two percent of the cases in 15 of the 17 studies.<sup>17</sup> Second, transient self-limited guilt or depression (the so-called "post-abortion hangover") lasting a few days or weeks may occur rather frequently.<sup>18</sup> Third, serious psychiatric reactions occur for the most part in two groups of patients: those who are pressured into abortion against their own judgment or against their religious or moral beliefs,<sup>19</sup> and those who were mentally disturbed prior to the abortion.<sup>20</sup> In this latter group, it is difficult to tell whether the psychiatric symptoms following the abortion were, in fact, the result of the abortion.<sup>21</sup> Fourth, only two studies, both of which are relatively old, found a high incidence of serious psychiatric problems following abortion. Both of these studies were performed in Sweden and found significant reactions in 10 to 12 percent of the cases.<sup>22</sup>

Admittedly, all of these studies together do not definitively settle the question of the psychiatric sequelae of abortion. For one thing, most of them have a relatively short period of follow-up (in no instance did it exceed 10 years). Therefore, the possibility that the women may develop depression later in life — at the time of menopause, for example — cannot be ruled out.

Another problem is that of experimenter bias. Most people have strong views on abortion and scientists are no exception. There is no way to ensure that the investigators were completely objective

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<sup>17</sup> See notes 23-39 *supra* & accompanying table.

<sup>18</sup> For example, Peck and Marcus found 19 percent of the patients to have such reactions. See note 25 *supra* & accompanying table.

<sup>19</sup> See note 25 *supra* & accompanying table.

<sup>20</sup> See notes 23, 24, 26, 28, 33, 34, 38, & 39 *supra* & accompanying table.

<sup>21</sup> *Id.*

<sup>22</sup> The Aren study found that 20 percent of the women regretted the abortion and would not go through the experience a second time if they again found themselves pregnant. See note 33 *supra* & accompanying table. Both studies suffer from the same methodological defect of failing to distinguish between symptoms resulting from abortion and those related to pre-existing psychiatric problems. In the Aren study, this distinction was not examined at all. In the Malmfors study, all the patients who showed psychiatric impairment after the abortion had a history of psychiatric symptoms prior to the abortion.

AUTHOR (S)	COUNTRY	PERIOD WITHIN WHICH THE ABORTION TOOK PLACE	NUMBER OF WOMEN	PERCENTAGE OF WOMEN WITH PRE-EXISTING PSYCHIATRIC PROBLEMS	LENGTH OF FOLLOWUP	RESULTS
Ekbal <sup>23</sup>	Sweden	1949-50	479	58	22-50 months	65% — satisfied. 10% — abortion unpleasant, but no self-reproach. 14% — mild self-reproach. 11% — severe self-reproach (1% had impaired capacity to work).
Simon et al. <sup>24</sup>	United States	1955-64	46	65	2 months-10 years	44 women suffered no ill effects that could be directly traced to the abortion. 2 women suffered psychiatric illness subsequent to the abortion.
Peck & Marcus <sup>25</sup>	United States	Sept. 1962-Nov. 1964	50	76	3-6 months	79% — no adverse effects after abortion. 19% — mild, self-limited guilt or depressive reaction. 1 patient, a devoutly religious woman pressured into abortion by husband, had acute upset; but was relieved of symptoms after 3 psychiatric interviews.
Patt et al. <sup>20</sup>	United States	Feb. 1964-Feb. 1968	35	100	3 months-4 years	75% — improved. 11% — unchanged. 14% — worse (2 women related worse condition to abortion; the other 3 did not).

Levene & Rigney <sup>27</sup>	United States	1968-70	70	71	3-5 months	86% — no harmful effects. 14% — reported increased depression, but none attributed this to the abortion.
Jansson <sup>28</sup>	Sweden	1952-56	1773	unknown	4 years	1.9% — developed psychiatric illness requiring hospitalization. In half of these, the hospitalization was unrelated to the abortion.
Clark <sup>29</sup>	Great Britain	1961-64	120	unknown	unknown	90% — satisfied with outcome of abortion. 2½% — acquiescent. 2½% — dissatisfied. 5% — unknown.
Mehlan <sup>30</sup>	Germany	1949-50	243	unknown	unknown	90% — thought abortion was best solution. 10% — regretted decision to have abortion.

<sup>23</sup> Ekblad, *Induced Abortion on Psychiatric Grounds*, ACTA PSYCHIATRICA ET NEUROLOGIC SCANDINAVICA 47 (Supp. No. 99, 1955).

<sup>24</sup> Simon, Zenturia & Rothman, *supra* note 1, at 59-61.

<sup>25</sup> Peck & Marcus, *supra* note 1.

<sup>26</sup> Patt, Rapport & Barglow, *Follow-up of Therapeutic Abortion*, 20 ARCHIVES GEN. PSYCHIATRY 408 (1969).

<sup>27</sup> Levene & Rigney, *supra* note 1.

<sup>28</sup> Jansson, *Mental Disorders After Abortion*, 41 ACTA PSYCHIATRICA SCANDINAVICA 87, 90 (1965).

<sup>29</sup> Clark, Forsner, Pond & Tredgold, *Sequels of Unwanted Pregnancy: A Follow-up of Patients Referred for Psychiatric Opinion*, 2 LANCET 501 (1968).

<sup>30</sup> Mehlan, *Abstract*, in THE YEARBOOK OF OBSTETRICS & GYNECOLOGY 36 (1957-58).

AUTHOR (s)	COUNTRY	PERIOD WITHIN WHICH THE ABORTION TOOK PLACE	NUMBER OF WOMEN	PERCENTAGE OF WOMEN WITH PRE-EXISTING PSYCHIATRIC PROBLEMS	LENGTH OF FOLLOWUP	RESULTS
Kolstad <sup>31</sup>	Norway	1940-53	135	unknown	3-16 years	82% — glad without reservation. 10% — satisfied but doubtful. 4% — not happy but knew abortion necessary. 4% — repentant.
Brekke <sup>32</sup>	Norway	1951-53	34	unknown	unknown	Only 2 women had even a slight transient reaction to abortion.
Ford et al. <sup>33</sup>	United States	1968-70	21	47	6 months	9 patients showed marked improvement in emotional status. 4 showed moderate improvement. 5 showed no change. 3 worse, but felt condition to be unrelated to abortion (all 3 had severe psychiatric problems preceding the abortion).
Barnes et al. <sup>34</sup>	United States	Jan. 1968-June 1970	114	43	1 month-2½ years	In 2 cases, there was worsening of the psychiatric condition after abortion, but it was unclear whether this was related to the abortion.
Kretzschmar & Norris <sup>35</sup>	United States	1960-65	26	unknown	1-5 years	No psychiatric problems resulted from the abortions.
Gillis <sup>36</sup>	Great Britain	April 1968-Dec. 1968	31	unknown	1 year	No significant psychiatric problems.
Osofsky & Osofsky <sup>37</sup>	United States	1971	250	unknown	shortly after abortion	45% — very happy. 20% — moderately happy. 21% — neutral. 10% — moderately unhappy. 4% — very unhappy.

Malmö <sup>88</sup>	Sweden	1948-50	84	12	approx. 2 years	46% — happy and satisfied with abortion. 12% — impaired mental health after abortion (since all had neurotic symptoms prior to abortion, not clear if impairment resulted from abortion).
Aren <sup>89</sup>	Sweden	1950-54	248	unknown	unknown	20% — dissatisfied with the abortion and said they would not go through with the experience again. 10% — severe guilt and associated psychiatric symptoms but not clear if these are related to the abortion.

<sup>81</sup> Kolstad, *Therapeutic Abortion*, 36 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA (Supp. No. 6, 1957).

<sup>82</sup> Report of Dr. Brad Brekke, summarized in ABORTION, *supra* note 16, at 135-36.

<sup>83</sup> Ford, Catelnuovo-Tedesco & Long, *Abortion: Is it a Therapeutic Procedure in Psychiatry?*, 218 J.A.M.A. 1173 (1971).

<sup>84</sup> Barnes, Cohen, Stoekle & McGuire, *Therapeutic Abortion: Medical and Social Sequels*, 75 ANNALS INTERNAL MED. 881 (1971).

<sup>85</sup> Kretzschmar & Norris, *Psychiatric Implications of Therapeutic Abortion*, 98 AM. J. OBSTETRICS & GYNECOLOGY 368 (1967).

<sup>86</sup> Gillis, *Follow-up After Abortion*, 1 BRIT. MED. J. 506 (1969).

<sup>87</sup> Osofsky & Osofsky, *The Psychological Reaction of Patients to Legalized Abortion*, 42 AM. J. ORTHOPSYCHIATRY 48 (1972).

<sup>88</sup> Malmöfors, *The Problem of Woman Seeking Abortion, summarized in ABORTION*, *supra* note 16, at 133-35.

<sup>89</sup> Aren, *On Legal Abortion in Sweden: Tentative Evaluation of Justification of Frequency During Last Decade*, 37 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA (Supp. No. 1, 1958).

in these studies and did not unconsciously overlook evidence of more serious postabortion problems than they reported. Nor is there any way to eradicate bias that may have influenced their judgments as to whether symptoms were the result of the abortion or due to pre-existing psychiatric illness. Until there are more studies in which systematic efforts are made to exclude experimental bias, these problems will remain.

Determining the presence or severity of psychiatric symptoms is highly subjective, and evaluating which of many influences in a person's life may be causing particular symptoms is often difficult. Even if a woman with no history of psychiatric problems develops clear-cut depression after an abortion, it does not necessarily follow that the abortion *per se* was the cause of the symptoms. The woman may be reacting to any number of related factors other than the abortion. For example, she may be having marital problems, or, if single, she may be encountering rejection from her family for having become pregnant out of wedlock or be reacting to abandonment by a boy friend.

Further, some hospitals permit abortion only if the woman will agree to be sterilized. In these cases, it may be the sterilization, with its connotations of mutilation and permanent loss of the ability to bear children, which is the cause of psychiatric symptoms. In other situations, such as in countries like Sweden where motherhood is strongly encouraged by the Government and where abortions are performed only where serious health problems exist, a woman must go through a long, humiliating series of consultations and convince a panel of doctors that there is something physically or mentally wrong with her in order to secure permission for an abortion. This experience can be degrading and dehumanizing and can contribute to the development of depressive symptoms even more than the abortion itself.

All of the studies reviewed were on women who obtained legal abortions. It must be remembered that legal abortions are, in many countries, a small percentage of the total abortions. In the United States, for example, prior to the recent passage of reform laws, it had been estimated that approximately one million women each year obtained illegal abortions.<sup>40</sup> The Institute for Sex Research studies found that between one-quarter and one-fifth of married wom-

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<sup>40</sup> It has been estimated that, in 1955, there were anywhere from 200,000 to 1,200,000 illegal abortions performed in the United States. Tietze & Lewit, *supra* note 5, at 29.



en had obtained an abortion by the time she reached age 45.<sup>41</sup> If abortions, especially the more traumatic illegal ones, were associated with a significant incidence of psychiatric illness, one would expect that abortion-related problems would be seen quite commonly in psychiatric practice. But, in fact, such problems are seen only rarely, which tends to support the findings of the follow-up studies. Doctor Kummer surveyed 32 practicing psychiatrists in California and found that 75 percent had never encountered any moderate or severe postabortion sequelae among their patients. Twenty-five percent encountered such sequelae only rarely, with the highest incidence being six cases in 15 years of practice.<sup>42</sup> Furthermore, the low risk of serious psychiatric problems following *abortion* must be contrasted with a relatively high frequency of psychosis following *childbirth*. There are some 4000 documented cases of post-partum psychosis requiring hospitalization in the United States each year, a little less than two per 1000 deliveries.<sup>43</sup>

In summary, the weight of available evidence suggests that serious psychological harm to women following abortion is a relatively rare occurrence. Most psychiatrists believe that, if a woman truly desires an abortion, the abortion is not in conflict with her basic religious and moral beliefs, and she is provided with emotional support by her family and physician at the time of the abortion, then the experience will be well tolerated psychologically. Although more follow-up studies would be a useful addition to our knowledge, most psychiatrists would be opposed to further delaying liberalization of the abortion laws for purposes of conducting further research. Sufficient research has already been done to convince the profession that abortion, in the great majority of cases, is a safe procedure from a psychiatric standpoint.

#### IV. DO UNWANTED BIRTHS HARM WOMEN?

One of the most widespread myths of American life is that pregnancy invariably is, or at least should be, a beautiful and ful-

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<sup>41</sup> P. GEBBARD, W. POMEROY, C. MARTIN & C. CHRISTENSON, PREGNANCY, BIRTH AND ABORTION 119 (1958). This is based on a somewhat nonrandom sample of over 5,000 married women. Assuming that most women in the United States marry at some time in their lives and that the above sample of married women is reasonably representative of the country as a whole, it is not unreasonable to further estimate that one out of every five women has obtained an induced abortion by the time she has reached the age of 45.

<sup>42</sup> Kummer, *supra* note 1, at 981.

<sup>43</sup> David, *Abortion in Psychological Perspective*, 42 AM. J. ORTHOPSYCHIATRY 61, 62 (1972).

filling event in the life of a woman. In reality, there are many circumstances in which an accidental pregnancy can be harmful for a woman and her entire family as well. The situations where this is most likely to occur are as follows.

*Unmarried women.* — For single women, or teenage girls, the birth of an illegitimate child can lead to loss of educational opportunities, diminished chances for a successful marriage, ostracism by family and friends, and to welfare dependency. Of course, it becomes more important to deal with this problem as the frequency of illegitimate births continues to rise, and during the period of 1940-68, the percent of births which were illegitimate rose from 3.5 to 9.7 percent.<sup>44</sup> To compound the situation, it has been estimated that at least 90 percent of these illegitimate births were unwanted.<sup>45</sup>

Moreover, illegitimate *births* are only part of the much larger problem of illegitimate *pregnancy*, since women with illegitimate pregnancies often obtain illegal abortions. In many other instances, the problem is solved by hastily arranged and often forced marriages. A recent study conducted by the National Center for Health Statistics found that 19 percent of legitimate firstborn children in this country during the period of 1964-66 were conceived out of wedlock,<sup>46</sup> and that 42 percent of the married women under age 20 had been married less than 8 months prior to the birth of their first child.<sup>47</sup>

These premature marriages have been shown to have a higher rate of divorce than marriages in which the bride was not pregnant at the altar. In one study, 4.9 percent of all sampled marriages ended in divorce as compared with a divorce rate of 13 percent among couples who had had their first child within nine months of marriage and 17 percent among couples whose first child was born within 6 months of marriage.<sup>48</sup>

It can be assumed that even when divorce does not occur, forced

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<sup>44</sup> BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 49 (1971). In 1968 alone, a total of 339,000 illegitimate babies were born. The figure represents 9.7 percent of the total births. *Id.*

<sup>45</sup> Cutright, *Illegitimacy: Myth, Causes and Cures*, 3 FAMILY PLANNING PERSPECTIVES 25 (1971).

<sup>46</sup> The study was based on a sample of women aged 15 to 44 which represents most women's child bearing years. NATIONAL CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, 18 MONTHLY VITAL STATISTICS REPORT 3 (Supp. No. 12, March 1970).

<sup>47</sup> *Id.* at 1.

<sup>48</sup> Christensen, *Child Spacing Analysis via Record Linkage: New Data Plus a Summing Up From Earlier Reports*, 25 MARRIAGE & FAMILY LIVING 272, 276 (1963).

marriages between unwilling and incompatible partners are less likely to be mutually satisfying than those marriages in which the couple made their decision freely. The awareness that one originally married because of love helps to sustain couples through the difficult times that occur in virtually all marriages. By contrast, it is hard for two people to build a relationship of loyalty and commitment when they feel they were forced into marriage in the first place.

Some people naively believe that most of the problems associated with unwanted pregnancy among the unmarried can be adequately solved by arranging for the women to give up their babies for adoption. Although it is certainly true that there are many unfortunate, infertile couples who would welcome the opportunity to adopt a child, giving up one's baby after nine months of pregnancy generally goes against the grain of human nature. The typical impulse for a woman is to want to keep her baby, rather than to give it away to a complete stranger. Despite pressure from families and social workers, many women will quite understandably refuse to place their babies for adoption, regardless of the problems that will inevitably occur in trying to provide adequate care for the child. Still other women resort to illegal abortions, rather than face the ordeal of giving up their babies for adoption.

*Physically ill women.* — Many women who suffer from serious illness lack the energy and strength to care properly for a baby. In some instances, these women already have more children than they can cope with. A woman with severe multiple sclerosis or rheumatoid arthritis, for example, undergoes a severe hardship if she bears an unwanted child merely because she has accidentally become pregnant. And with some diseases, such as cancer, the patient's prognosis may show a life expectancy of only a few months or years. The abortion laws of most states would not allow a woman, even in this situation, to abort an accidental pregnancy.

*Mentally ill women.* — Serious mental illness, including alcoholism and drug addiction, is characterized by extremely low tolerance for frustration and stress. When mental patients are exposed to more stress than they can handle, their symptoms — anxiety, depression, psychotic behavior, excessive use of drugs or alcohol, etc. — become even worse. An unwanted pregnancy can be a major stress even for a "normal" woman, but for mental patients, an unwanted pregnancy can be overwhelming and lead to exacerbation of

her symptoms, suicidal tendencies, or complete psychotic breakdown.<sup>49</sup>

*Women with severe situational problems.* — Many women, although basically "normal" with respect to their emotional and mental stability, are burdened by personal problems or pressures which generate considerable nervous tension. The birth of an unwanted child in these circumstances can increase these pressures to an intolerable degree. Such situations would include women whose husbands are alcoholics or are physically ill, women who are unhappily married or in the process of divorce, and women who already have more children than they can adequately manage.

*Women in poverty.* — In many families, the size of the breadwinner's paycheck is inadequate to provide for the needs of a large family. If these couples can limit their number of children to one or two, the family can remain solvent. Limiting the family size can also help the family's financial situation by providing sufficient free time for the mother to hold a part-time or full-time job and augment the husband's earnings.

In poor families, several unwanted children can create severe economic hardship and can increase strains within the family to the breaking point. The family's income, which might have been adequate for a small family must now attempt to meet the housing, nutritional, clothing and recreational needs of several more people. With a large number of children to care for, the mother is less likely to find time for gainful employment; and if she does take a job, it is at the cost of denying her children much-needed maternal care, guidance, and discipline. In circumstances such as these, it is quite common for the husband to desert the family. And women who have been deserted by their husbands and who are forced to try to raise a large family on welfare, frequently sink into a chronic

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<sup>49</sup> Another possible outcome following the birth of an unwanted child to a mentally disturbed mother is that the mother will lose control of her aggressive impulses and beat or even murder the baby. It has been estimated that between 30,000 and 37,000 children are badly beaten by their parents each year. Zalba, *The Abused Child: A Survey of the Problem*, 11 SOCIAL WORK 3, 8 (1966). Furthermore, one study indicated that as many as 50 percent of these children may have been unwanted. *Id.* at 7.

A study by Resnick of 131 children murdered by a parent found that 14 percent of the murders were motivated by the child being unwanted. See Resnick, *Child Murder by Parents: A Psychiatric Review of Filicide*, 126 AM. J. PSYCHIATRY 325, 329 (1969). Another study by Resnick of 37 neonaticides (a child murdered by the parent within 24 hours of birth) found that 83 percent could be classified as resulting from the child's being unwanted. See Resnick, *Murder of the Newborn: A Psychiatric Review of Neonaticide*, 126 AM. J. PSYCHIATRY 1414 (1970).

state of apathy or depression or turn to drugs or alcohol for escape.<sup>50</sup>

*The elderly mother.* — Many accidental pregnancies occur in women in their 40's who are entering menopause and who already have adult children. Having already devoted 20 or so years to raising their families, these women are often incapable of making the considerable emotional and psychological adjustment that would be required for them to initiate a second career of motherhood, devoting an additional 20 years to the care of children.

*Women made pregnant by rape.* — Even the most vehement opponents of abortion reform will admit that women made pregnant as a result of a criminal assault ought not to be forced to bear the offspring. Yet, some opponents of abortion will argue that the occurrence of rape is not a satisfactory reason to change the abortion laws. They point out quite correctly that immediately following rape, a woman can undergo a surgical procedure (dilation and curettage of the uterus) which will, in most cases, prevent pregnancy from occurring. They also argue that many instances of rape are not bona fide, and that women frequently contribute to the assault by seductive behavior. They also contend that if rape were included as a justifiable ground for abortion, any woman could claim that she had been raped in order to get an abortion, thus allowing easy circumvention of the law's prohibitions.

In view of the traumatic nature of rape, however, these arguments seem very callous. Forcible rape is a common crime and one which is occurring with increasing frequency. According to FBI reports, 37,000 rapes were reported in 1970, a 121 percent increase from 1960.<sup>51</sup> Moreover, these statistics fail to reflect the true magnitude of the problem because rape is one of the most under-reported crimes. Few women who have been raped wish to report this to the police, press charges against their assailants, or participate in a trial where they will be subjected to public embarrassment.

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<sup>50</sup> Approximately 40 percent of all children born into poor families are unwanted. See Bumpass & Westoff, *The "Perfect Contraceptive" Population*, 169 *SCI.* 1177, 1179 (1970).

Surveys show that couples with incomes of less than \$3000 desire the same number of children, three per family, as couples with incomes of greater than \$10,000. Jaffe, *Family Planning and Poverty*, 26 *J. MARRIAGE & FAMILY* 467 (1964).

For more detailed discussion of the relationship between family planning and poverty, see H. SHEPPARD, *EFFECTS OF FAMILY PLANNING ON POVERTY IN THE UNITED STATES* (published by W. E. Upjohn Institute for Employment Research 1967); Campbell, *The Role of Family Planning in the Reduction of Poverty*, 30 *J. MARRIAGE & FAMILY* 236 (1968).

<sup>51</sup> BUREAU OF THE CENSUS, *supra* note 44, at 140.

Because rape is such a terrifying and humiliating experience, it is unrealistic to expect a woman who has been raped to immediately seek proper medical attention against her natural impulse to suppress the incident. Consequently, there is little practical merit to the argument that current medical procedures alone are adequate to deal with cases of rape, without a change in the laws as well.

And finally, there is no proof that a large percentage of rape victims are willing accomplices; to suggest this is to indicate little more than prejudice and contempt towards women. In our present crime-ridden society, to deny women who have been forcibly and criminally impregnated an opportunity to terminate the pregnancy under safe medical conditions is, at the very least, inhumane.

*Woman made pregnant as the result of incest.* — An incest-caused pregnancy is another case which most compassionate people concur should be a grounds for abortion. The exact incidence of incest is not known, but psychiatrists are aware from their practices that incest is not extremely rare, as many people believe. Clearly, an enlightened society should not insist that a 12- or 13-year-old child must bear the offspring of her deviate father.

*Woman who simply do not desire children.* — Many women, both single and married, prefer careers to motherhood; still others may wish to delay motherhood until later in life in order to first pursue educational or career goals. Such women justifiably regard it as an "extreme hardship" to be forced, because of an unwanted pregnancy, to abandon goals for which they have worked or planned throughout their lives. And finally, many women may simply prefer not to have children, regardless of any extrafamilial interests. It is difficult to see why the state should compel these women to continue unwanted pregnancies — the state's interest is minimal, whereas the impact on the women's personal lives is tremendous.

It has been shown that there are many situations and circumstances in which a woman may be unable to adequately assume the burdens and responsibilities of motherhood. Forcing her to bear an unwanted child in these situations can impose severe strain upon her mental and physical health and well-being. Until the time that fool-proof contraceptive methods are invented and made readily available to all women, easy access to abortion is the only way that many thousands of women each year can be spared from bearing an un-

wanted child.<sup>52</sup> Making it possible for all women to choose the number and spacing of their children would contribute greatly to the protection of the emotional health of American womanhood and, secondarily, would contribute substantially to the stability of the family unit as a social institution.

#### V. ABORTION, THE UNWANTED CHILD, AND THE PREVENTION OF PSYCHIATRIC DISORDERS

Psychiatrists generally agree that the single most important cause of mental disorders is inadequate parental care during the formative years. Children need generous amounts of affection, guidance, and discipline in order to develop into intellectually and emotionally mature adults. Children who feel rejected and unloved or who are given inconsistent or ineffective discipline have a much greater than average likelihood of developing serious psychiatric disorders such as schizophrenia, alcoholism, drug addiction, mental retardation, or a psychopathic personality.<sup>53</sup> Raising a child successfully is a demanding and difficult task requiring love and dedication on the part of the parents for some 20 years.

It seems reasonable to assume that, all things being equal, the child who is wanted is far more likely to receive a high quality of parental care than one who is unwanted. Unmotivated parents who have the burdens of child-rearing thrust upon them because of accidental and unintentional pregnancy are less likely to raise a child as well as parents who have freely chosen to assume this responsibility. Most psychiatrists believe, therefore, that allowing the couple to decide the number and spacing of their children without compulsion by the state would decrease the percentage of unloved and inadequately reared children and, consequently, would decrease the incidence of psychiatric disorders.<sup>54</sup> The noted psychiatrist Karl Menninger has expressed this idea well:

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<sup>52</sup> For further discussion of this point, see notes 75-89 *infra* & accompanying text.

<sup>53</sup> Selected references representing literature showing the relationship between adverse experiences in childhood and subsequent mental disorders are: J. BOWLBY, *CHILD CARE AND THE GROWTH OF LOVE* (1965); I. CHEIN & D. WILNER, *THE ROAD TO H* (1964); S. GLUECK & E. GLUECK, *UNRAVELLING JUVENILE DELINQUENCY* (1950); Pavenstedt, *A Comparison of the Child Rearing Environment of the Upper-Lower, and Very-Low-Lower Class Families*, 35 *AM. J. ORTHOPSYCHIATRY* 89 (1965); Saul & Wenar, *Early Influences on Development and Disorders of Personality*, 34 *PSYCHOANALYTIC Q.* 327 (1965).

<sup>54</sup> See Lieberman, *Preventive Psychiatry and Family Planning*, 26 *J. MARRIAGE & FAMILY* 471 (1964); Schwartz, *The Role of Family Planning in the Primary Prevention of Mental Illness*, 125 *AM. J. PSYCHIATRY* 1711 (1969).

The reason that contraceptive knowledge and counsel seem to the psychiatrist to be essential is based not upon considerations of the welfare of the adult, but on the considerations of the welfare of the child. Nothing is more tragic, more fateful in its ultimate consequences, than the realization by a child that he was unwanted. . . . [P]lanned parenthood is an essential element in any program for increased mental health and for human peace and happiness. The unwanted child becomes the undesirable citizen, the willing cannon-fodder for wars of hate and prejudice.<sup>55</sup>

Admittedly the notion that unwanted children are more prone to develop psychiatric disorders, despite its common-sense appeal, has never been adequately tested scientifically because of intrinsic research problems. For example, the time interval required for follow-up studies of this kind (where the attitude of the parents at pregnancy is correlated with the subsequent life adjustment of the offspring) is 20 years or more. Few researchers are willing to commit themselves to a project spanning that length of time. Another problem is presented by the difficulties which attend the assessment of whether the mother or father "wanted" the child.<sup>56</sup>

The only pertinent study that has been carried out thus far was a 21 year follow-up study of 120 children born after their mother had been refused a therapeutic abortion. The investigators found that, compared with control subjects, the unwanted children: (1) had a higher incidence of many kinds of behavioral maladjustments; (2) required more psychiatric care; (3) were arrested more often for antisocial and criminal behavior and drunkenness; (4) received welfare assistance more frequently; and (5) failed to achieve as high a level of schooling as did the control group.<sup>57</sup> Similar studies are in progress at the present time and it would be quite surprising if they produce significantly different results.

Further indirect confirmation of the assumption that unwanted children are more prone to mental illness is provided by recent research on the relationship of birth order to mental illness. Studies analyzing large groups of psychiatric patients with varying diagnoses show that, in families with four or more children, the children in the last half of the birth order were more likely to develop mental

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<sup>55</sup> Menninger, *Psychiatric Aspects of Contraception*, THERAPEUTIC ABORTION 250-51 (H. Rosen ed. 1954).

<sup>56</sup> Responses to the question whether the couple wanted the child are not necessarily reliable. For further discussion of this problem see Pohlman, "Wanted" and "Unwanted": *Toward Less Ambiguous Definition*, 12 *EUGENICS* Q. 19 (1965).

<sup>57</sup> Forssman & Thuwe, *One Hundred and Twenty Children Born After Application for Therapeutic Abortion Refused*, 42 *ACTA PSYCHIATRICA SCANDINAVICA* 71, 78-84 (1966).



illness than children in the first half of the birth order.<sup>58</sup> In one of these studies, it was also shown that, compared to first-born patients, last-born patients were sicker and showed a lower degree of social competence and a higher incidence of bizarre and self-destructive behavior.<sup>59</sup> The most probable explanation for these findings is that later-born children in large families are more likely to be unwanted and hence are more likely to receive poorer parental care in childhood. Indeed, a recent survey has shown that only 11 percent of parents with two children said that their last-born child was unwanted, whereas the corresponding figures for parents with three, four, five, and six children was 28, 41, 45 and 47 percent, respectively.<sup>60</sup>

In the face of such a sparse body of research on the subject of the life outcome of the unwanted child, it can be asked whether it is scientifically defensible for mental health professionals to recommend the legalization of abortion on the grounds that doing so would lead to a reduction in the incidence of mental illness. An affirmative position on this question can be justified on the following grounds (each of which will be discussed at length in the next section). First, methods of curing or preventing psychiatric disorders — other than the preventive approach of improving family planning services — all have serious limitations. Second, the public health problem of mental illness is of such serious proportions that, in the absence of *proven* remedies, those measures judged to be *most likely to be effective* should be adopted as soon as possible. Third, the number of unwanted children born in the United States each year is substantial, so that a reduction in the incidence of such births can be expected to decrease the rate of mental illness. And finally, legalization of abortion is the single most effective step that can be taken to reduce the incidence of unwanted births.

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<sup>58</sup> See Barry & Barry, *Birth Order, Family Size and Schizophrenia*, 17 ARCHIVES GEN. PSYCHIATRY 435 (1967); Farina, Barry, Henry III, Garnez & Norman, *Birth Order of Recovered and Nonrecovered Schizophrenics*, 9 ARCHIVES GEN. PSYCHIATRY 224 (1963); Gregory, *An Analysis of Familial Data on Psychiatric Patients: Parental Age, Family Size, Birth Order, and Ordinal Position*, 12 BRIT. J. PREVENTIVE SOCIAL MED. 42 (1958); Gregory, *Family Data Concerning the Hypothesis of Hereditary Predisposition Toward Alcoholism*, 106 J. MENTAL SCI. 1068 (1960); Schooler, *Birth Order and Hospitalization for Schizophrenia*, 69 J. ABNORMAL & SOCIAL PSYCHOLOGY 574 (1964); Schooler, *Birth Order and Schizophrenia*, 4 ARCHIVES GEN. PSYCHIATRY 91 (1961).

<sup>59</sup> See Schooler, *Birth Order and Hospitalization for Schizophrenia*, *supra* note 58.

<sup>60</sup> P. WHELPTON, A. CAMPBELL & J. PATTERSON, *FERTILITY AND FAMILY PLANNING IN THE UNITED STATES* (1966).

A. *Alternative Methods of Curing or Preventing  
Psychiatric Disorders*

If effective methods for the treatment of psychiatric disorders were available, all that would be needed to achieve a reduction in the number of psychiatrically disturbed people would be to establish adequate numbers of appropriately staffed treatment facilities. Unfortunately, modern psychiatric treatment methods, consisting mainly of group and individual psychotherapy and drugs, are most effective in relatively mild disorders such as neuroses, depressions, and acute psychoses. These techniques are of limited benefit in the severe disabling disorders such as chronic schizophrenia, severe alcoholism, drug addiction, and the psychopathic personality or chronic criminal offender. Individuals afflicted with severe disorders frequently lack motivation for treatment, or even insight into the fact that they are disturbed. If treatment accomplishes anything at all, it is slight palliation of the worst symptoms, rather than a cure. Moreover, years of patient work by highly trained professionals is necessary to accomplish even modest goals. Because of the overwhelming difficulties, few mental health professionals seriously believe that a treatment-oriented strategy will significantly reduce the numbers of people afflicted with mental illness. The only realistic hope to control mental disorders is to take preventive measures.<sup>61</sup>

Unfortunately, the outlook for finding effective methods for preventing the occurrence of psychiatric disorders is little better than the outlook for curing them. Because the main cause of these disorders is inadequate parental care during the formative years of childhood, preventing mental illness would require either: influencing parents to take better care of their children; or providing supplementary or corrective child-rearing services to those children who are not being properly cared for at home. Both of these approaches, however, have major difficulties which make them extremely difficult to implement.

It would be desirable to educate or otherwise influence all parents to bring up their children properly, but there is, of course, no known way of accomplishing this goal. Most incompetent parents either have multiple personal problems of their own which divert their energies from their parental responsibilities, were so poorly raised themselves that they failed to observe and learn how to be effective

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<sup>61</sup> See, e.g., G. CAPLAN, PRINCIPALS OF PREVENTIVE PSYCHIATRY (1964).

parents, or have manifest emotional disorders or subnormal intelligence. And our society lacks both the knowledge and the resources to alter any of these factors on a mass scale.

Even if we had a network of special parent education or counseling centers, and these facilities were capable of accomplishing their task, many of the parents who needed these services would fail to utilize them unless coerced. In order to select the inadequate parents for required counseling, it would first be necessary to determine which parents were failing in their responsibilities, which in turn would require a nationwide system of surveillance of home and family life. It is doubtful that the American public would tolerate such a massive invasion of privacy, even assuming that a relatively efficacious system could be made to work.

A seemingly more practical approach to preventing mental illness would be to provide supplementary or corrective child-rearing services for deprived or neglected children through institutions other than the family. The Head Start program<sup>62</sup> is a beginning effort in this direction. A two-billion dollar comprehensive child development program recently passed by Congress,<sup>63</sup> but vetoed by President Nixon,<sup>64</sup> was an even more ambitious attempt along these lines.

But based on existing knowledge about child development, one has to be skeptical about whether these kinds of programs would accomplish what their proponents contend they will. A few hours a week of contact with a child care professional during the preschool years would have little impact upon the personality development of a child in comparison with the impact of the mother who is with the child much more time. In order for child care centers to have a substantial influence upon the personality of the child, they would need to have access to the child at a very early age and for many hours each day. The staff-child ratio would have to be high and efforts would have to be made to provide continuity so that the child could form a meaningful relationship with one or more workers. In effect, this would mean replacing the family as the principal child-rearing institution of our society by something similar to the kibbutz system in Israel, where child-rearing is a community, rather

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<sup>62</sup> 42 U.S.C. § 2809(a)(1) (1970) (originally enacted as Economic Opportunities Act of 1964, Pub. L. No. 88-452, tit. II, § 222(a)(1), 78 Stat. 508).

<sup>63</sup> Economic Opportunity Amendments of 1971, S. 2007, 92d Cong., 1st Sess. (1971).

<sup>64</sup> ECONOMIC OPPORTUNITY AMENDMENTS OF 1971 — VETO MESSAGE, H. DOC. NO. 92-48, 92d Cong., 1st Sess., S 21129 (1971).

than a family, responsibility.<sup>65</sup> There is little likelihood, it would seem, that such a drastic change in our traditional family-centered way of life would be accepted by the American public in the foreseeable future.

Thus, one important reason for advocating improved methods of family planning as a means of preventing mental illness, despite the lack of *conclusive* proof that unwanted children are more prone to these disorders, is that few if any alternative methods promise to control mental illness.

#### B. *Psychiatric Disorders — A Major Public Health Problem*

If psychiatric disorders were a relatively minor social or public health problem, it would be sensible to delay the adoption of control measures pending further research. This research would increase the possibility that all remaining unanswered questions concerning the etiology of these disorders could first be resolved, which in turn would increase the likelihood that any programs adopted would prove effective. But the extent and severity of the mental illness pandemic makes such a leisurely approach unjustifiable.

Psychiatric disorders often lead to extreme suffering and anguish, not only for the persons affected but for their families and associates as well.<sup>66</sup> The children of schizophrenics, drug addicts, and alcoholics, for example, are particularly vulnerable to emotional trauma because of the constant turmoil to which they are exposed in the home.

Psychiatric disorders also impose enormous costs upon the general society in several ways. First, there are the costs of operating the nation's network of mental hospitals, clinics, and alcoholism and drug addiction facilities.<sup>67</sup> Second, there are the costs of operating that portion of the criminal justice system (police, courts, jails, and

<sup>65</sup> See B. BETTLEHEIM, *THE CHILDREN OF THE DREAM* (1969).

<sup>66</sup> One indication of this is that suicide is one of the leading causes of death in the United States, claiming 22,000 lives in 1969. BUREAU OF THE CENSUS, *supra* note 44, at 58. Many authorities believe at least half of all suicides go unreported in order to protect survivors from embarrassment or to enable them to collect life insurance benefits.

<sup>67</sup> In 1968, a total of 3,381,000 mental patients were treated in the nation's mental hospitals and outpatient clinics. The cost of mental illness, which would include the treatment for these three million patients, has been estimated at 20 billion dollars annually in the United States. BUREAU OF THE CENSUS, *supra* note 44, at 73. See also Conley, *An Approach to Measuring the Cost of Mental Illness*, 124 AM. J. PSYCHIATRY 755 (1967).

prisons) which is involved in dealing with the alcoholic,<sup>68</sup> the drug addict,<sup>69</sup> and the chronic criminal offender.<sup>70</sup> Third, because most of the severely disturbed and retarded<sup>71</sup> are unable to work, there is the cost of maintaining these persons and their families. Fourth, there are intangible costs such as the diminished sense of safety in the community because of the rising rate of crimes of violence, many of which are committed by seriously disturbed individuals. As a corollary to the high crime rate, the survival of many of our free institutions is endangered. As public pressures mount for effective action against crime, police practices such as preventive detention and wire-tapping, hitherto considered alien to American traditions, seem likely to gain increasing public acceptance.

Considering these consequences, it is no surprise that mental illness is often termed the nation's number one health problem.<sup>72</sup> To

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<sup>68</sup> The number of alcoholics in the United States is estimated at nine million, making alcoholism far and away the nation's worst drug problem. U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, FIRST SPECIAL REPORT TO THE U.S. CONGRESS ON ALCOHOL AND HEALTH viii (1972). Alcohol also plays a major role in half the highway fatalities in the United States which each year claim thousands of lives. *Id.* Furthermore, public intoxication accounts for one-third of all arrests reported annually. *Id.* The percentage of arrests would rise to between 40 and 49 percent if such alcohol-related offenses such as driving while intoxicated, disorderly conduct, and vagrancy were considered.

Cirrhosis of the liver, most cases of which are the result of alcoholism, is one of the leading causes of death in the United States. BUREAU OF THE CENSUS, *supra* note 44, at 58.

<sup>69</sup> The rate of addiction to hard narcotics has been growing in our large central cities and appears to be spreading to suburban areas. It has been estimated that there are 650,000 heroin addicts in the United States, and 400,000 in New York City alone. MED. WORLD NEWS, Feb. 16, 1971, at 20. Death from heroin overdose is a leading cause of death among teenagers in New York City. There were 447 of these deaths in 1970. MED. WORLD NEWS, April 16, 1971, at 6. Moreover, heroin addicts are responsible for a large proportion of "street crimes" in urban areas.

<sup>70</sup> A high proportion of crimes of violence — aggravated assault, rape, robbery, and homicide — are committed by persons with a history of persistently antisocial behavior and other signs of severe maladjustment. See K. MENNINGER, THE CRIME OF PUNISHMENT 162-89 (1966), which contains an excellent discussion of the personality makeup of criminals. In the decade 1960 to 1970, the rate of violent crimes rose 157 percent. BUREAU OF THE CENSUS, *supra* note 44, at 140. In 1970, there were, according to FBI statistics, a total of 16,000 homicides, 37,000 forcible rapes, 330,000 aggravated assaults, and 348,000 robberies. *Id.*

<sup>71</sup> An estimated two to three percent of our population is mentally retarded and in need of some support or supervision in order to live in the community. Seventy-five percent of these retarded persons have no demonstrable brain damage and are classed as "familial" (that is, their retardation is caused by a combination of genetic factors and inadequate child-rearing practices). Zigler, *Familial Mental Retardation: A Continuing Dilemma*, 155 SCI. 292 (1967).

<sup>72</sup> See *Hearings on H.R. 3689 Before the Subcomm. on Public Health and Safety of the House Comm. on Interstate and Foreign Commerce*, 88th Cong., 1st Sess. 105 (1963). In 1968 alone, 3,381,000 mental patients were treated in the nation's mental hospitals and outpatient clinics. BUREAU OF THE CENSUS, *supra* note 44, at 73.

combat mental disorders, some risks clearly seem warranted even if, after several more decades of research, it should turn out that some approach other than birth control might have been more effective in attacking this problem. Policy makers have an obligation to adopt those remedies that appear most likely to produce desired results on the basis of existing knowledge, rather than wait for some kind of definitive answers which may not be available for many years, if ever.

### C. *The Incidence of Unwanted Births*

If the numbers of unwanted births in America were low, preventing their occurrence would obviously have little impact on the public health problem of mental illness. It would, under those circumstances, make little sense to press for improved techniques of family planning as a high-priority method for preventing mental illness.

Recent studies, however, have shown that the incidence of unwanted births is actually far higher than had been suspected previously. Based on interviews with 5600 married women during the period of 1960-65, Professors Bumpass and Westoff of Princeton found that approximately 19 percent of the children born during that period were unwanted.<sup>73</sup> The Bumpass and Westoff study was limited to married women and therefore gave only a partial and overly optimistic view of the entire problem of unwanted pregnancies. When one further considers that approximately nine percent of all births are illegitimate (339,000 in 1968) and that an estimated 90 percent of the illegitimate births are unwanted, a more complete picture of the problem materializes.<sup>74</sup> For example, in

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I would rank psychiatric illness second behind cardiovascular diseases, which cause 50 percent of all deaths, on the basis of the number of persons afflicted, the extent of their suffering, and the costs involved.

<sup>73</sup> The women were asked whether, prior to the beginning of a given pregnancy, they and their husbands had decided that they did not want to have more children at any future time. If the answer was affirmative, the child was considered to have been unwanted. This assumes that, had the couple been using a perfect contraceptive, the child would not have been born.

The researchers believe that the true rate of unwanted births is higher than 19 percent because they assume that many women, not wishing to acknowledge that any of their children were in any sense unwanted, gave false responses to the interviewers.

In addition to the findings concerning unwanted births, Bumpass and Westoff also discovered that an additional 43 percent of births were timing failures (the couple did not want to have a child at that particular time, but had not necessarily decided to have no more children in the future). Only one-fourth of all the couples in the study were successful in preventing both unplanned and unwanted births. Bumpass & Westoff, *supra* note 50.

<sup>74</sup> See notes 44-46 *supra* & accompanying text.

1967 the total of unwanted *legitimate* births (19 percent of 3,203,000, or 608,500) and unwanted *illegitimate* births (90 percent of 318,000, or 286,000) was 894,000. In other words, 25 percent of all births were unwanted in that year. That close to 900,000 unwanted births are occurring each year in the United States clearly shows that our present system of family planning is falling far short of the goal of ensuring that all children born are wanted children.

D. *Is Abortion the Most Effective Way to Reduce Unwanted Births?*

Even if one accepts the idea that reducing the incidence of unwanted births deserves high priority as a method of preventing psychiatric disorders, one could still question whether legalization of abortion is the best way to accomplish that reduction. One might question, for example, whether the same objective could be reached by some other means such as contraception.

Unfortunately, analysis of the current state of birth control technology suggests there is little likelihood that we can significantly reduce the incidence of unwanted births in the foreseeable future without legalizing abortion. Our present methods of contraception have three serious drawbacks which are quite difficult to overcome: technical imperfections, inadequate distribution, and human error.

*Technical imperfections.* — There is only one contraceptive method that is “fool-proof,” the contraceptive pill.<sup>75</sup> The next most reliable method is the intrauterine device (IUD), which has a failure rate of approximately two to three percent per year (*i.e.*, for every 100 users, two to three will become pregnant each year).<sup>76</sup> This may seem like a high rate of reliability, but with 25 million fertile American women, there would be 250,000 accidental pregnancies annually, even if every woman used a 99 percent effective method.<sup>77</sup> Moreover, these high rates of reliability are misleading because all women will not be using either of these two high-reliability methods. Many women who begin using the pill stop because of its side-effects, while others refuse to use the pill because of the chance of dangerous side-effects. The same is true for the

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<sup>75</sup> Segal & Tietze, *Contraceptive Technology: Current and Prospective Methods*, reprinted in REPORTS ON POPULATION/FAMILY PLANNING 4 (Oct. 1969).

<sup>76</sup> *Id.*

<sup>77</sup> Hardin, *The History and Future of Birth Control*, 10 PERSPECTIVES IN BIOLOGY & MED. 1, 11 (1966).

IUD, where uterine bleeding and pain is a major factor in its removal.<sup>78</sup> Furthermore, the likelihood that 100 percent reliable and well-tolerated contraceptive method will be developed in the near future appears remote.<sup>79</sup>

*Inadequate distribution.* — There are two large groups in our population who lack access to contraception: the poor and the unmarried young. Planned Parenthood-World Population has calculated that only 30 percent of the five million fertile, low-income women in the United States were served in 1971 by publicly or privately subsidized family planning programs.<sup>80</sup> And efforts to expand these programs are running into increasing difficulties because of opposition from a number of corners, including minority groups who contend that birth control programs are a form of genocide.<sup>81</sup>

There is strong opposition on the part of society at large to providing contraception to the unmarried young, despite evidence that a large percentage are sexually active. The public seems to believe that providing contraception to unmarried teenagers would lead to an increase in sexual promiscuity and to a weakening of the moral fabric of society. Since these beliefs are deep-rooted, there seems to be little reason to believe that they will change in the near future.

*Human error.* — The third problem with contraception is that its successful practice requires more foresight and self-discipline than many people possess. The very people who are least capable of raising children properly, the mentally retarded and emotionally unstable, are the same people least capable of successfully using contraception. Until methods of contraception can be developed

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<sup>78</sup> Segal & Tietze, *supra* note 75, at 9.

<sup>79</sup> Djerassi, *Birth Control After 1984*, 169 SCI. 941 (1970).

<sup>80</sup> Harkavy, et al., *Family Planning and Public Policy: Who is Misleading Whom?*, 165 SCI. 367 (1969).

<sup>81</sup> Black sociologist, Professor Charles V. Willie of Syracuse University has said: I must state categorically that many people in the black community are deeply suspicious of any family planning program initiated by whites. You probably have heard about but not taken seriously the call by some male-dominated black militant groups for females to eschew the use of contraceptives because they are pushed in the black community as "a method of exterminating black people." While black females often take a different view about contraceptives than their male companions, they too are concerned about the possibility of black genocide in America. The genocidal charge is neither "absurd" nor "hollow" as some whites have contended. Neither is it limited to residents of the ghetto, whether they be low-income black militants or middle-aged black moderates. Position paper by C. Willie, Professor and Chairman, Department of Sociology at Syracuse, presented to the President's Commission on Population Growth and the American Future, *reprinted in* Population Reference Bureau, selection No. 37, Population Reference Bureau, Inc. (1971).



which do not depend on foresight or self-discipline, this problem cannot be overcome.

Abortion has none of these shortcomings. Abortion is not 97 or 99 percent reliable, but 100 percent. Moreover, once it is legalized, abortion can be made readily available to the young<sup>82</sup> and the poor without encountering great political or societal opposition, as the experience in New York City has shown.<sup>83</sup> In the first nine months after New York State's liberalized abortion law went into effect, 55 percent of the 31,382 New York City residents who obtained abortions were poor,<sup>84</sup> 34 percent were performed in public hospitals,<sup>85</sup> and more than half of the patients were unmarried.<sup>86</sup>

Since abortion requires no foresight or self-discipline, legalization of abortion would make it possible for the most immature, emotionally unstable, or mentally retarded woman to achieve total control over her reproduction. The segment of the population least able to properly raise children would no longer have thrust upon them large and unwanted families.

If abortion were legalized, there could be a great reduction in the incidence of unwanted births. In the first 9 months after New York liberalized its abortion law, 31,382 abortions were performed on New York City residents, or 447 abortions for every 1000 live births in that city.<sup>87</sup> If this ratio were projected to the United States as a whole, where 3,731,000 babies were born in 1970, this would lead to a national "abortion demand" of some 1,700,000 annually.<sup>88</sup> Although many legal abortions terminate pregnancies that would have been aborted illegally before the laws were liberalized, Dr. Tietze has estimated that approximately 20 percent of the legal abortions performed in New York during the first 9 months under the new law ended pregnancies that otherwise would have become unwanted births.<sup>89</sup> If we apply this 20 percent figure to the

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<sup>82</sup> Permitting unmarried teenagers to abort is not seen by the public as encouraging promiscuity to quite the same extent as providing them with contraceptives.

<sup>83</sup> Pakter & Nelson, *Abortion in New York City: The First Nine Months*, 3 FAMILY PLANNING PERSPECTIVES 5 (1971).

<sup>84</sup> *Id.* at 5.

<sup>85</sup> *Id.* at 6.

<sup>86</sup> The exact figures on marital status were not known at the time of this study, but a sample survey showed that more than half of aborted resident women were unmarried. *Id.* at 8.

<sup>87</sup> *Id.* at 6.

<sup>88</sup> *Id.* at 12.

<sup>89</sup> Tietze, *The Potential Impact of Legal Abortion on Population Growth in the United States*, prepared for The Comm. on Population Growth and the American Future (1971) (on file in the Case Western Reserve Law Review office).

1,700,000 legal abortions that would be expected in the United States if abortion were allowed upon request, the number of unwanted births that would be prevented would be 340,000 (20 percent of 1,700,000). In other words, the present annual total of approximately 900,000 unwanted births occurring in the United States could be reduced by 38 percent merely by the single step of legalizing abortion nationwide. This is a far greater reduction of unwanted births than could be achieved by any other single measure.

## VI. CONCLUSION

The proponents of legalization of abortion have, during the past decade, emphasized two principal arguments: First, that the denial of a woman's right to choose whether or not to bear a child is unjust and oppressive; and second, that the abortion laws force women to break the law and risk their lives at the hands of a criminal abortionist. These two arguments have intense emotional appeal and serve as rallying cries for mass demonstrations and other forms of political action by pro-abortion groups.

Although both these arguments are certainly valid, other aspects of the abortion problem, particularly its social implications, have received inadequate attention. The legalization of abortion would contribute greatly to alleviating many of our most serious social problems, especially over-population and poverty. In this article, I have emphasized the anticipated impact of legalization of abortion on the social problem with which I am most familiar — mental illness and related behavioral disorders. By bringing about a sharp reduction in the incidence of unwanted births, now estimated to be 25 percent of all births, legalizing abortion would contribute to the mental health and well-being of society in several ways. Many thousands of women would be spared from severe hardship and suffering currently brought about by the birth of children under adverse circumstances. Opportunities for women to fulfill their educational and career aspirations would be significantly enhanced. And the proportion of children born who would receive adequate parental care during their formative years would increase, which in turn would decrease the number of children who would become mentally ill, alcoholic, mentally retarded, addicted to drugs, or criminals in later life.

If the potential social benefits to be derived from legalization of abortion, in terms of improvement of family life and mental health, are as substantial as I have suggested, one wonders why they have

not been more widely recognized. Part of the reason may be that the idea of using abortion as a method of solving social problems runs contrary to many of our customary patterns of thought — it is “counter-intuitive.” Abortion is a “negative” concept in most people’s minds. It is associated with interference with, or destruction of, the basic natural processes of life, and it is also associated with the notion of irresponsibility (opponents of abortion argue that, if people conscientiously use contraception they would not need abortions). People intuitively look for “positive” rather than “negative” ideas for solving social problems. Thus, most proposals for improving the mental health of the population involve one form or another of service to people — educational programs, day care centers, mental health centers, rehabilitation programs for criminals, and the like. One naturally tends to assume that the larger these programs are and the more money they cost, the more “positive” they are and, therefore, the better the end result will be.

Legalization of abortion goes contrary to this whole set of assumptions, for it does not involve the institution of large-scale and expensive government service programs. Instead, all that is required is that society leave women alone to pursue their own personal wishes and desires. Instinctively we resist the idea that such a “negative” social policy could achieve major social benefits. Merely because we may not regard abortion per se as intrinsically noble or morally uplifting, we should not blind ourselves from recognizing that legalization of abortion may well contribute substantially to the solution of many social problems. Although legalizing abortion is not a panacea and will certainly not totally eliminate mental illness it is difficult to think of any single measure that would do more to reduce the incidence of serious psychiatric disorders.